The emergence of the occupation of district nursing in nineteenth century England

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"Nursing, especially that most important of all its branches - nursing of the sick poor at home - is no amateur work"

Florence Nightingale, 1865

Abstract

This research examines the genesis of district nursing in England, and in particular explores the way in which district nursing became a paid occupation over the course of the nineteenth century. District nursing is defined as the care of the sick poor within their own homes, which is consistent with a nineteenth, rather than a twentieth, century meaning.

At the beginning of the century an occupation of district nursing did not exist, yet by the end a formal occupation had emerged, and some associations of district nursing were attempting to create a profession which would attract educated women.

In order to explore the processes involved, empirical data were obtained from the records of nineteenth century district nursing associations and organisations for their affiliation. These were interpreted and analysed within the theoretical framework of the sociology of work, occupation and professions, the concept of occupation being regarded as crucial in explaining the emergence of district nursing. Since district nursing was an exclusively female occupation, particular emphasis is given to the gender division of labour.

It was found that social changes associated with urbanisation and the rise of capitalism in an age of enlightenment thinking, facilitated a move from an informal to a paid occupation. This was not, however, a linear progression, since philanthropic pursuit, particularly that of women, played an important role in the formation of most associations and in constructing power relationships. The first associations were Protestant Sisterhoods where

subjective labour (Freidson 1978) dominated and controlled the work of paid nurses. By the end of the century most nurses were part of the official economy (Freidson 1978), yet the involvement of philanthropic effort continued.

Diversity among emerging associations hindered the development of a unified occupation with a discrete area of work and occupational identity, which in turn circumscribed the attempts of some organisations to create in district nursing a profession of educated women.

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INTRODUCTION

The history of district nursing has suffered from the primacy given to hospital nursing, especially in the voluntary hospitals, with reforms and changes that took place there being assumed to influence other forms of nursing by a ripple effect.

Previous histories of district nursing which look beyond this approach have usually been chapters in more general histories of nursing (e.g. Dingwall *et al* 1988). The two best known works which concentrate solely on district nursing are Stocks (1960) and Baly (1987).

Stocks took the year 1860 as her starting point for *A hundred years of district nursing*, although recognising that there had been previous district nursing ventures, and, like most traditional histories, concentrates on the work of William Rathbone[1] in Liverpool as being the beginning of district nursing in England. Although the first sentence of the book asks when district nursing began, she does not question why it began, and rather takes the rationale and the process for granted. This is very much a Whig history, a chronological account of developments and milestones in the history of district nursing.

Baly, by her own admission, was commissioned to write the history of the Queen's Nursing Institute in a specific way, as determined by the Institute.[2] The result is a celebration of the progress of district nursing.

Neither work takes an explicit theoretical position, and neither questions the genesis of district nursing as a paid occupation. Both acknowledge that nursing

in the home has always been carried out, and give examples from ancient times, but neither explores at a conceptual level the shift to a formal occupation which occurred over the course of the nineteenth century. They also concentrate on the well known district nursing associations, mainly in large cities, at the expense of smaller ones in towns and more rural areas.

More critical histories have, however, been written about other occupations, and other branches of nursing work (Rafferty 1996, Witz 1992). These have challenged traditional nursing histories of gradual progress brought about by increasing knowledge and more discrimination in the employment of nurses, usually by using a case study approach. This has also been a feature of other work on the development of occupations (e.g. Macdonald 1995, Abbott 1988). General nursing, mental health nursing, health visiting *inter alia* all now have written histories based on critical analysis and contextualisation. This research aims to create for district nursing the type of analytical history that Witz (1992) produced on nurse registration, or Carpenter (1977) on managerialism; a sociological study of an occupational development. Even these critical histories, however, tend to concentrate on professionalisation. In this thesis the genesis and development of an occupation are seen as crucial.

Apart from 'filling a gap', my interest in the area is mainly professional. As a lecturer in health policy and in sociological analyses of nursing, I have long been aware of the focus of histories of medicine and nursing on the voluntary hospital as the inspiration and locale for changes in health care during the nineteenth century. Most people, however, would not have had entitlement to care in a voluntary hospital when sick, nor would they have readily entered a poor law infirmary. Nevertheless, social and economic changes engendered by

the industrial revolution and urbanisation would suggest that caring for the sick or old was more difficult to incorporate into daily life than in pre-industrial times, especially for the poor. This, then, raises the question of what happened to the poor when sick? If they were not being cared for in large numbers in hospitals, then who was caring for them? As stated above, histories of nursing the sick at home showed that there were paid nurses, and that by the end of the nineteenth century a formal occupation existed. At least some of these nurses were attempting to professionalise. What is largely left unacknowledged, or assumed to be a steady progression towards professional status, is the process by which the occupation came into being and evolved. This is a central question in the history of district nursing, since professionalisation as such was a minority interest.

In order to produce a more critical history of district nursing it is necessary to make explicit, and to sociologically unpack, some of these 'taken for granted' issues. In terms of the genesis of district nursing, it is not enough to describe what happened. We need to explore how and why it was that tasks that had previously been carried out informally came to be seen as more appropriate to a paid occupation. What was it about the social and economic conditions of the period that facilitated that change? Can sociological theories of occupation and professionalisation offer a useful explanation of the genesis and development of district nursing?

To begin with, what do I mean by district nursing? The work carried out and the clientele have changed over time, but as this study is concerned mainly with the nineteenth century, I will use terms in a way in which I feel reflects their usage at the time.

Domiciliary nursing I am using as a generic term to cover all nursing carried out in people's homes.

District nursing was the care of the sick poor in their own homes. Nurses would normally visit patients at intervals, and therefore see many patients in a day.

Private duty nurses formed the majority of domiciliary nurses, and they nursed those who could afford to pay for a full time nurse. They usually lived in patients' homes for the duration of their illness and nursed them continuously. Many nurses carried out both roles, sometimes within the same job. District nurses were employed by district nursing associations, which may also have employed nurses for private patients, but voluntary hospitals also acted as agents for private duty nurses.

This thesis will take a thematic approach to exploring the genesis and development of district nursing, and will move away from the case study or chronological approach taken in previous histories of occupations. This should allow for a more detailed analysis of what was a diverse occupation, and facilitate discussion of the many associations that existed, not just the well researched ones of London and Liverpool.

I begin in chapter 1 by reviewing the literature on nursing history, and demonstrating the focus on the voluntary hospital, and on hospital nursing, as the arena for developments in nursing. The dominant view of nursing as progressing from an occupation whose practitioners were inebriate and untrustworthy to one where they were respectable and obedient is challenged; I also cite literature which highlights the way in which domiciliary nursing was hidden from history, even though it was in fact influential in setting and

maintaining standards and training for nurses in hospital. Why is it that the dominant version of history, and the exclusion of non-institutional nursing, has perpetuated?

There are logistical and ethical issues concerning the use of historical data, and these are discussed in chapter 2. Records and correspondence are retained in a very partial manner, so that what is available to the researcher, and the uses to which it may be put are highly problematic, as is looking at the past from the standpoint of the present. My own sources of data, and a brief account of each of the district nursing associations whose surviving records I have consulted are also described here.

In chapter 3 I address the genesis of occupations and the way in which work becomes accepted as an occupation. Sociologists have long theorised on the process of professionalisation, but less is written about the genesis of occupations. The concept of occupation is frequently used as a starting point on the road to professionalisation, and rarely problematised or acknowledged as a topic worthy of sociological analysis in its own right. In district nursing both concepts fall within the timescale of this thesis, but as stated above the concept of occupation is crucial.

At the beginning of the nineteenth century nursing was carried out in the homes of the poor by relatives, or a handywoman within the local community. By the end of the century it was an established occupation, some of whose members were attempting to professionalise. How useful are different sociological perspectives in explaining these developments? Occupational closure, developed by Weber (see 1968) and refined by Parkin (1979) and Witz (1992), it will be argued, provides an explanation of the strategies adopted in district

nursing, and will be utilised to sociologically underpin empirical evidence obtained from archive data. However, in view of what Halliday (1987) calls the neo-Weberian obsession with professional self interest, Abbott's (1988) concept of jurisdiction will also be used in the analysis. It allows for occupations to be simultaneously altruistic and self interested, which is a feature of many district nursing associations, and it also includes the genesis and development of occupations, which is assumed in closure theory.

It has been stated above that developments in district nursing were influenced by the great changes in economic and social structure which accompanied the industrial revolution, and particularly urbanisation. The next two chapters will explore those changes most relevant for the development of district nursing. Issues of class and space in urban and rural areas and the major public health issues of the nineteenth century will be considered first, providing a macroscopic view of the setting in which district nursing took place.

Nursing was considered naturally women's work, and so developments in district nursing were inextricably linked with ideas surrounding appropriate roles for women, and with differential ideas about women of different classes. Women's 'natural' world was perceived to be the private world of the home, and ideals of 'home' were those espoused by the emergent middle classes. Chapter 5 considers why 'home' emerged as both a physical and a social structure, and questions the extent to which what have come to be known as Victorian values influenced the form that district nursing took. One escape from the cult of domesticity for middle class women was through philanthropic pursuit, which in an age of liberalism, produced a type of philanthropy which was historically specific. The symbiotic relationship between women, home and

philanthropy will be demonstrated as determining the specific nature of district nursing. Chapters 4 and 5 also highlight the interplay between structure and agency as an important facet of social change.

The next three chapters all consider the structure and work of some of the district nursing associations which began during the nineteenth century, but as stated above they will be for the most part addressed in a thematic manner. The first district nurses to be formally organised into associations in England were the Protestant Sisterhoods, and chapter 6 will concentrate on these, as well as other associations based around religious beliefs. Why was it that some women and the established church wanted to re-establish Sisterhoods at this time, and why did they perceive nursing as being an appropriate vehicle to utilise? Whether different religious sects viewed their role with the sick poor differently, and whether they had different ideas from the secular societies which started later in the century will also be considered.

Chapter 7 considers the organisation and working practices of district nursing associations, and viewing work as both a collection of tasks and as a social activity, demonstrates a great diversity among them. It is argued that this diversity was important in hampering strategies aimed at making the occupation a profession for educated women towards the end of the century. Little common ground could be identified in training, supervision and the relationship between district and private duty nurses, so that the opportunity for a unified occupation to develop, with clear boundaries and a defined area of work, was limited. There were also many actors involved, of whom the nurses themselves were usually the least powerful (an exception being that the people visited by district nurses were among the least powerful in society). In view of this the

question is addressed - whose interests were served by the development of district nursing progressing in a particular way?

Chapter 8 considers the diversity identified in chapter 7 and asks whether it was too great for attempted professionalising strategies to work. Utilising the sociological perspectives on occupation and professionalisation discussed in chapter 3, and the gender division of labour discussed in chapter 5, the strategies adopted by some district nurses towards the end of the century are explored. Who was instrumental in the initiation of such strategies, and who opposed them? It is argued that for most associations professionalisation was not an issue, and was, therefore a minority interest. In the absence of a united occupation agreed on jurisdictional boundaries and an occupational identity, professionalisation was unlikely to succeed.

Notes

[1] William Rathbone was a member of a wealthy Liverpool shipbuilding family, Member of Parliament, and founder of the Liverpool School.

[2] 'The pitfalls of writing history' Paper given at 'Nursing, women's history and the politics of nursing' conference. University of Nottingham 1996. Baly stated that she would have liked to have written a more qualitative account using the experiences of Queen's nurses themselves. This is not, however, the same as the kind of critical account presented here.

CHAPTER 1

Discourses of nursing history

Introduction

History has in the past often been approached unproblematically, with the result for nursing that a dominant version of history, concerned with the lives of a few elite individuals and the deeds they accomplished, has formed the major part of the literature. The narrative of nursing history has traditionally focused on people such as Florence Nightingale or Edith Cavell, and attempts to change nursing from an occupation of the inebriate and untrustworthy to one suitable for respectable women. The locale for most histories has been the hospital, particularly voluntary hospitals.

This chapter will begin by critiquing this interpretation of nursing history, before placing domiciliary nursing in a more central position, providing a rationale for the more detailed examination which forms the substance of this thesis.

A critique of traditional nursing history

In speaking of early nineteenth century Britain and Europe Masson (1985:39) describes nursing in the following terms:

> Unfortunately, however, the nursing staff in Protestant hospitals in England and on the continent still came from poor backgrounds, were untrained, and often given to drink and promiscuity with their male patients.

Contemporary literature gave support to this idea of nursing. In Martin Chuzzlewit, Dickens described the face of the nurse Mrs. Gamp "the nose in particular - was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits" (Dickens 1958:313).

In these discourses of nursing history the solution to the problem of drunken, dishonest and promiscuous women entering nursing was for the selective recruitment and training of respectable women to take nursing out of the hands of paupers; women such as Florence Nightingale who had a calling and who "knew in her heart of hearts that she would never marry and must dedicate herself to her life's work" (Masson 1985:47). Heasman (1962:234) notes that although there had been previous attempts to improve standards of nursing care, the "dynamic influence upon the development of nursing" was Nightingale, and the catalyst for change the Crimean War.

> Nursing could never be the same after the Crimean War. The popular image of the nurse had been transformed. Sairey Gamp was no longer the typical nurse; it was Florence Nightingale, the lady of the lamp. Never again would the nurse be typified as a tipsy, promiscuous man chaser. Instead the nurse now had to bear the image of Florence Nightingale - strong yet compassionate, controlled in the face of suffering, yet seeking only to relieve the distress of her fellow man. (Bullough 1964:101)

These examples demonstrate the Whiggish nature of traditional nursing history. Some popular histories also perceive the triumphalist development of nursing from dishonest and drunken to trustworthy and sober as being synchronous

with the reign of Queen Victoria, and therefore reflecting the changing moral values of the period.

This type of history builds on contemporary writing, not only in popular fiction, but also within medicine and nursing itself. At an inaugural lecture, delivered on the opening of the school of nursing at St. Bartholomew's hospital, Dyce Duckworth MD in 1877 commented:

> Many years ago it was commoner far than now to meet with dishonest and drunken nurses. ... Such wretched women are of course unfit for any responsibility, much more for such noble service as care of the afflicted ones of humanity, and they soon meet their doom in dismissal and degradation. (Duckworth 1877:23)

These accounts led to the building of myths, many of which became dominant thinking, and further reinforced the idea of Florence Nightingale as a strong and brilliant organiser who transformed nursing into a respectable occupation. As a member of the English upper classes who had shown humanitarianism and sacrifice in a highly publicised way, she was "a perfect vehicle whereby nursing could lever itself into a respectable occupational status and integrate itself into society as a respectable work role" (Whittaker and Olesen 1964:126).

An example of these myths, cited by Baly (1986), is the belief that the Nightingale training school, opened in 1860 at St. Thomas's hospital was immediately successful and provided rigorous training, lectures, supervision and assessment for probationers. As Baly points out there was a high wastage rate, ill health, and dismissal for misconduct (including insobriety). Probationers received little instruction, and few kept the diaries with which Nightingale reputedly kept abreast of nurses' training. The Nightingale school is also fabled

as being independent of the hospital. The Nightingale fund paid for fifteen probationers to train at the hospital, and therefore educational needs were supposedly paramount, yet Nightingale herself complained about probationers being used as staff to carry out the work of the hospital, and not receiving regular time off for lectures and instruction.[1] It was not until 1875 that she wrote to Bonham Carter that it was only during the past year that St. Thomas's had really been a school, "a place of moral, religious and practical training."[2] These myths are, however, cited as evidence of the Nightingale school's influence in transforming nursing into a respectable occupation.

While I do not wish to deny the importance of Florence Nightingale, these traditional histories fail to take into account the social context in which women such as her were able to operate. In particular class and gender relations are ignored, concepts which will be identified as central and recurring themes throughout this thesis, but a dimension that is almost always absent is race. While Nightingale was in the Crimea, a black nurse, Mary Seacole, was running another hospital there, the British Hotel for medical treatment, and yet she is excluded from most histories. Even Nightingale is not remembered for her achievements as medical statistician, reformer of the medical corps of the British army, and architect of the Indian sanitary commission, but for those deeds which conform to the stereotype of the Victorian woman.

The first real challenge to this version of nursing history was Abel-Smith (1960), but this was not extended until Davies (1980), although there had been earlier work which challenged some dominant assumptions and examined areas of previous neglect. As early as 1948, for example, Anderson (1948:418) wrote

about a "forgotten or overlooked" attempt to extend the field of nursing to include home care.

Not all were enthusiastic about nursing reform, and many doctors viewed it with suspicion (Moore 1988). There was a general feeling that educated nurses would only add to the strong competition already present amongst medical practitioners. Summers (1989) also points to the fact that the medical profession was becoming increasingly crowded, and for doctors to make a living they had to demonstrate their indispensability to their patients, and their superiority to nurses. According to some of the medical literature and national press of the time, institutional nursing should remain at the level of domestic duty.[3]

Until recently few writers of nursing history have utilised concepts from the sociology of occupations in order to examine these issues, or related issues in domiciliary nursing.[4] Yet debates surrounding the definition and appropriation of an area of work were highly influential in the development of nursing, and will form a major focus of this thesis.

The vilification of nurses and their 'rehabilitation'

Summers (1989) argues that virtually no research had been carried out on nursing before Nightingale and others set out to reform the occupation, and that the stereotype of Sarah Gamp has been perpetuated over time. "1860, the year in which Florence Nightingale opened her training school for nurses at St. Thomas's hospital is the traditionally accepted starting point for nursing reform" (Gamarnikov 1991:111). Abel-Smith (1960) points out that nursing had been steadily improving for many years. The Training Institution for

Nurses in Hospitals, Families and the Poor[5] opened a training school for nurses in 1849, and Nightingale consulted its Superintendent when setting up the Nightingale School. By appointing a lady superintendent to control both nursing and domestic arrangements, and by training educated women who could then train the probationers, St. John's House changed the organisation of nursing to a degree that the Nightingale school did not (Helmstadter 1994/5).

Images of the drunken and dishonest nurses persisted however, and as Abel-Smith (1960:5) points out:

> it is not unusual for reformers to overstate the evils that they seek to correct.... Such evils as there were, arose largely from the system under which the old nurses were expected to work. There were features both of employment in the voluntary hospitals and in the workhouses which led to abuses.

This is borne out by contemporary rationalisations of nurses' drinking. "It is a notorious fact that old nurses were more or less given to drinking. What was the cause? Simply that the overtaxed strength required a stimulant, and thus laid a foundation for that fearful and degrading habit."[6] In 1857 the Bishop of Lichfield commented at the annual meeting of St. John's House that hospital nurses were "many of them notorious for their habits of intemperance; for which I admit there was some excuse in the painful scenes they had to go through."[7]

Much theft by nurses seems to have been of food, and any drunkenness may be explained by the fact that many nurses were paid partly in ale. The reputation of nurses may well have been because of unrefined behaviour, rather than any dishonesty, as in the case of Elizabeth Woodward, (cited by Summers 1989)

who was reported by the relative of a patient to be too noisy and to leave half eaten food on the table. In 1742, for example, the board of governors of Westminster Hospital had:

> expressed itself tired of continually having to dismiss nurses for drunkenness and debauchery. Why was it members asked, that the women engaged seemed consistently to be of the very poorest quality? If they did not drink or stay out all night, or tempt the porter or the apothecary's pupil, they either became incurable or died on the hospital's hands. (Langdon-Davies 1952:50)

The persistence of the idea of nurses as dishonest, promiscuous and drunken does, however, require explanation, and no explanation of the position of nurses can be attempted without reference to social class and gender.

Versluysen (1980) points out that until well into the nineteenth century healers, many of whom were female, competed with medical men for patients. Part of the response to this competition was a process of vilification of other health workers by doctors, along with a claim to unique knowledge and expertise.[8] Historians have uncritically accepted and colluded with this position in their dismissal of other health workers as amateur and marginal to health care. There was some truth in tales of drunken nurses stealing from patients, as in any unregulated system standards will vary considerably.

If there was callousness in the attitudes towards the sick this was a reflection of wider society's attitude towards the poor, what White (1978:8) describes as "a callousness throughout life as judged by 20th century attitudes". The largest variation in nursing standards was between voluntary and workhouse hospitals, but many hospitals required nurses to be obedient, and to treat the patients with kindness (e.g. Manchester Infirmary, the Radcliffe Infirmary, cited in Dingwall

et al 1988, Liverpool Infirmary, cited in White 1978). A provincial hospital cited by Stanley (1855:21) reported "The only testimonials required are an ordinary character for sobriety, morality and general respectability." Relying on hospital records for information can give a biased interpretation, for as Dingwall *et al* (1988) point out, dismissing a nurse for drunkenness generates documentation, whereas good nursing care would not, and the fact that nurses were dismissed for stealing, drinking etc. would suggest that hospitals were trying to maintain a good standard of care. Examples of this from domiciliary nursing can be found in chapter 7.

Reform did not bring to an end incidents of poor practices and standards. The 1875 Report of the Association for Providing Trained Nurses for the Sick Poor[9] commented that although the purloining of food and drink was less common than it once was, it probably existed far more than the authorities admitted. What is clear is that before reform not all nurses were dishonest and inebriate, and that following reform not all were honest and sober. Changes in nursing were evolutionary, rather than revolutionary.

As the reputation of nursing improved, it became acceptable work for women within the sexual division of labour, and the characteristics required for a 'good nurse' were considered those seen in a 'good woman' (Gamarnikov 1978). The doctor - nurse - patient relationship within this hierarchical occupational structure is analogous to the Victorian family of husband - wife - child. The nurse's sphere of authority was within the ward setting, where the sister was responsible for the care of patients and the supervision of staff. In the same way that a wife's responsibility for running a household did not threaten the ultimate

authority of her husband, so a nurse in charge of a hospital ward did not alter patriarchal relationships within the hospital setting. Alluding to the family structure meant that the nurse's position as subservient, and consisting of caring, domestic tasks, was assumed to be natural and went unquestioned. The aim of reformers was to change nursing, not to overturn the hierarchical structure of health care (Gamarnikov 1978). Carpenter (1977) points to the Victorian class structure as the basis of the hospital structure with a division of labour between the sexes and between women of different classes.

The maxim of good woman equalling good nurse was one frequently repeated by Nightingale, and reinforced in the training schools for nurses:

> But so exactly is sick-nursing a field for female energy, that I regret to find cultivated women expending their powers in a wrong direction, and robbing the ranks of skilled nursing sisters to form a band of imperfectly trained medical practitioners. (Duckworth 1877:12)

The traits possessed by women, which made them naturally suited to nursing were "discipline, obedience, faithfulness" (Duckworth 1877:14). Similarly, "nursing is distasteful to men, who naturally yield to the gentler sex the more tender and delicate ministrations required by the sick" (Duckworth 1877:13). The naturalness of this situation was held to be God given:

> The more pains we take to call forth and employ the faculties which belong characteristically to each sex, the less will it be intruding upon the province which, not the convention of the world, but the will of God, has assigned to the other. (Duckworth 1877:12)

The sexual division of labour has been utilised differentially by men, especially doctors, and female nurse reformers. Reformers attempted to create in nursing

an autonomous female occupation "within an unquestioned hierarchical mode of work and authority distribution between nursing and medicine" (Gamarnikov 1978:102). They did not propose to challenge the status quo in regard to power relationships. In this they used the ideas discussed above, which equated nursing work as identical to the domestic and caring role women had within the home, and which defined the role as exclusively female:

> Nursing reformers took the ideology of femininity and turned it on its head, using an ideological mechanism which had been used to deny women the right to remunerated work to argue for a redefinition of the meaning of the sexual division of labour. (Gamarnikov 1984:11)

Reformers argued that the 'natural' sexual division of labour should not be restricted to a division of the sexes into public or private worlds, but should be extended into the public sphere, thereby allowing women to perform the role for which they were uniquely qualified in public institutions as well as in the home. "If the sexual division of labour was natural, then it was a natural element in all social life, not just the family. Excluding women from participation in the public sphere was, in fact, unnatural" (Gamarnikov 1984:12). Women thus used the argument of sexual division of labour in an enabling manner, in order to achieve acceptance of nursing as a respectable female occupation, and access (in later years) to professional status. This was, however problematic for nurses.

In adopting their 'separate but equal' policy to open up the labour market for women, nursing reformers refused to address critically the issue of male and/or medical power (Gamarnikov 1984:17).[10] This allowed male doctors to continue to use the sexual division of labour to assert patriarchal dominance over nurses.

"The sexual division of labour, like all ideological constructs, was elastic enough to permit diametrically opposed accounts" (Gamarnikov 1984:17). Doctors had seen a threat to their professional dominance from a new breed of educated, middle class nurses, and used the concept of sexual division of labour in a restrictive way, to suppress professionalisation. As nurse training became established, it espoused the subjects of the medical school curriculum (albeit in watered down fashion), which produced a skilled assistant for doctors. They in turn were able to rely upon traditional patriarchal power relationships to maintain their dominance, by reinforcing the idea of nursing as women's work. "Women are peculiarly fitted for the no less onerous task of patiently and skilfully caring for the patient in faithful obedience to the physician's orders" (male doctor cited by Gamarnikov 1984:16).

Williams (1980) argues that these different views of the development of nursing led to a historical interpretation of events which reflected different occupational interests, within popular histories. She uses the historical works of a nurse, Miss Breay, and an anonymous doctor, reflecting on the changes in nursing on Queen Victoria's Golden Jubilee to show how this occurred. From her perspective as a nurse Miss Breay saw the foundations of reformed nursing laid down by Fry for home nursing as being important, but awards Nightingale the title of chief pioneer because of her influence on the development of hospital nursing. Nightingale, Miss Breay viewed as not only reforming nursing but also the "relationship that should obtain between nurses and other hospital workers" (Williams, 1980:50), this being the increasingly centralised system of control which placed all nursing in the hands of a female matron. Along with training, this would transform the status of nursing from that of servant to educated

pupil. The reforms were therefore regarded in a positive light, as being of benefit to nurses and patients.

The medical opinion of nurses (as portrayed by an anonymous doctor cited by Williams) was of women who were prepared by early experiences for the work they undertook. Nightingale's reforms were perceived as a continuation of what was already happening (instigated by St. John's House, following the work of Elizabeth Fry) to make nursing a respectable occupation. When nurses such as these entered hospitals, it was through the sisterhoods and therefore they retained their feminine characteristics, that is they were willing to be subservient and to carry out the nursing tasks as defined by a doctor. This view was echoed by Beale, in the introduction to his clinical lectures at King's College Hospital in 1873:

> Every old nurse was eminently deferential, and in a way thoroughly under the control of the constituted authorities. Though the discipline seemed lax in some particulars, and the work was often most carelessly performed, there was never any doubt who was master and who served. (Beale 1873:630)

Many doctors wanted nurse training to retain this status of nursing, and viewed it as being akin to the improvements taking place in the conditions of domestic servants in late Victorian England, with whom nurses were often compared.

Trained nurses, on the other hand, the anonymous doctor saw as possessing too much theoretical learning, and as Gamarnikov (1984) notes, the trained ward sister would not accept medical definition of nursing tasks, but would translate medical orders into nursing tasks, which she would then delegate.

Both the nursing and medical historians, writing at the same time, of the same events formulate interpretations of those events, and the status of the individuals involved, which support their own point of view of what nursing should be. "The facts of nursing history, of what it was and now is, seem thus to be judged and interpreted according to what each historian thinks it ought to be" (Williams 1980:53).

The persistence of histories which saw nursing as moving from dishonesty to respectability, Williams (1980:58) perceives as working in the interest of the philanthropic movement, which was attempting to change nursing in a way that required a change in social arrangements:

> I suggest that the characterisation of the hospital nurse as 'Sarah Gamp' was created at the time to support philanthropic claims for changes that were based on different ideals and different social arrangements from those that obtained, and that it is a reputation rather than a set of facts that has become incorporated into popular nursing history.

These different social arrangements related to the separation of domestic and nursing duties, and to the idea of probationers who were selectively recruited and trained in the manner of Sisters of St. John's House. These probationers were eligible for promotion to sister, whereas the traditional hierarchy of hospitals comprised nurse, sister and matron, each of whom was drawn from a different social class, and remained within that grade or office. Each grade had its own prescribed duties.[11]

Williams (1991) also explains the impetus for reform of nursing as being influenced by philanthropic evangelicals, who were concerned about lack of moral standards, rather than technical incompetence in nurses. Merchants and

factory owners, who were persuaded to espouse evangelism in great numbers, were ubiquitous on voluntary hospital boards.

White argues that the perpetuation of traditional nursing histories as a celebratory exercise is "useful in the socialisation of new entrants to the occupation, as a means of imbuing them with an ideology of service and dedication" (White 1986:ix). It has sustained a traditional base, which is learned by all new recruits and which colours their responses to change. Davies (1980:11) has pointed out that most histories of professions are written from within and "written with a special professional purpose, namely to give the neophyte an everlasting faith in his (*sic*) profession". Rafferty (1996:1) states that nurse education has been "characterised by the inculcation of moral values and virtues, rather than intellectual prowess".

Whittaker and Olesen (1964:123) argue that "those aspects of reality which support the favoured image are the ones recognised, while other factual data is either not sought, or is allowed to slip into oblivion". Therefore the elements from the lives of significant individuals, or from events that reflect contemporary values become the base on which dominant history is built. Citing Malinowski, they contend that myths are enhancers and codifiers of belief, which reinforce existing values by expressing them as concrete images. The popular image of Nightingale, for example, reflects aspects of femininity which are culturally desirable but, as has been discussed earlier, the achievements of her life which do not represent ideal womanhood are not part of the image. The desired values of nursing are embodied in Florence Nightingale, and new recruits are presented with her as the ideal nurse:

> Characteristically a culture-heroine functions as a reflector of the values of the social group which reveres her. Her image is invested with the ideal actions and attitudes to which the group members aspire. In times of discord and change the legends of the culture-heroine function to reduce social strain and to integrate disparate themes. (Whittaker & Olesen 1964:127)

Whittaker and Olesen found that the use of the culture-heroine differed in different types of nurse training institution. Traditional hospital schools of nursing retained much of the task orientation of the nineteenth century, and valued submission to authority, whereas university nursing departments allied themselves to other professional departments within the university, and stressed the professional autonomy of nurses. The teaching on Florence Nightingale in each type of nursing course reflected these differences in ethos.

For example schools of nursing taught about the hard work and sacrifice of her time in the Crimea, but universities relegated her work in Crimea, and highlighted her achievements as bio-statistician and social reformer. Like Miss Breay and the anonymous doctor, these institutions are portraying the progress of nursing in a manner that reflects their own philosophy of what nursing is and should be, for the induction of students.

Traditional nursing histories, then, have had the effect of constructing nursing in a certain way, and creating certain values which become internalised by members of the occupation. These values are perpetuated and reinforced, with major implications for the way nursing develops. The recent resurgence of interest in Seacole, an interest which can be construed as constructing a heroine figure in the same way as Nightingale, indicates that both conservative and radical histories may adopt the same strategies.

The exclusion of domiciliary nursing from nursing history

The almost exclusive concentration of historians on hospital nursing is an example of present-centredness.[12] Summers (1989) states that the failure to look beyond the stereotype of Sarah Gamp, who was a domiciliary nurse reflects a lack of interest in non-institutional nursing. Nursing as an occupation did not exist before the nineteenth century, and there was a wide range of healers with different skills, some paid and others unpaid who cared for the sick. The vast majority of sick people were cared for at home by family, or by someone from the local community. Except for the treatment of accidents and major surgery, hospital was not thought of as the natural place for the treatment of illness, whether major or minor. In the 1860s St. Bartholomew's Hospital, for example treated c6,000 in patients, but had c71,000 out patients.[13] The consultation of licensed medical practitioners was available to very few (for geographical as well as financial reasons), and voluntary hospitals were selective in the type of patient whom they would accept. Their reputations were not advanced if people died on the premises, so that most patients would be suffering from self limiting illness, or visible conditions (e.g. boils, fractures, open wounds). They were admitted only with letters of recommendation from subscribers. In London, especially in the teaching hospitals, doctors wanted to treat short stay patients on whom they could demonstrate quick and successful results, thereby attracting pupils, and a favourable reputation. As power over admissions shifted from subscribers to honorary consultants over the first half of the nineteenth century, the consequence was that the burden of chronic ill health and infectious diseases was not addressed by the voluntary hospitals. In

addition, most people were averse to entering poor law infirmaries, and therefore much ill health was encountered in the community.

Writers like Heasman who did refer to domiciliary nursing were concerned with reporting the work of the evangelical movement, as it extended its work to the nursing of the sick in the home, and so the care of the sick was covered as one aspect of the evangelical mission. The London Bible and Domestic Female Mission,[14] for example, began as a bible society, but much time was spent by the bible women in sitting with the sick at night and offering help, which tired them for their bible duties and "is not fair to our mission if it happens too often".[15] In 1868 a nursing mission began, with working class bible women, who, it was thought, would be acceptable to the sick poor, being trained in hospitals for three months, before starting work as nurses. The proselytising aspect of the work remained paramount, however, and nurses were expected to be "watching everywhere for the fitting opportunity to drop a word that shall turn the eye of the sufferer upwards towards the great physician".[16] The bible nurses were supervised by middle class volunteers, who acted as superintendent and met the nurses weekly in order to receive their reports and to pay their wages. As with hospital nurses, position in the hierarchy was determined by social class, rather than ability.

The mid nineteenth century was a time of government preoccupation with public health and sanitation, yet little recognition is given to the part played by visiting societies in this area, by the advice given on a personal level regarding health and hygiene, and the policing function of this, an aspect which will be discussed later in relation to poor law nursing.

There seem to be two reasons for the dominance of hospital nursing in the history of nursing, which demonstrate the problem of present-centredness. First, as hospitals are formal institutions they maintain records, many of which survive, and their presence is highly visible and accessible. Secondly, hospitals, especially in the acute sector dominate the provision of health care today, and so, in addressing history from the standpoint of the present, it is easy to assume their dominance in the past. Indeed, one reason often postulated for changes in nursing has been advances in medical technology and surgical technique, requiring a better educated and reliable helper. Therefore changes in the nature of nursing have been characterised as part of the changing nature of voluntary hospital provision for the sick poor.

Caring and healing in domestic settings, on the other hand was largely hidden from the public arena. Little documented evidence exists, partly because of the informal nature of the transaction between healer and client, and partly because not all involved would be literate. Rafferty (1995) states that nursing was more of an oral than a written culture.[17] Any surviving diaries and records would be scattered among personal records.

That formal nursing in the home was a significant part of care for the sick is demonstrated by the 1861 census (cited by Summers 1992) which distinguishes between domestic and institutional nurses. There were 24,821 domestic nurses recorded as opposed to 4,448 institutional nurses (including asylum attendants), of whom 1651 were men. Many of the domestic nurses would have been private nurses employed by the well off during episodes of sickness, who would have been beyond the means of the poor. The number of district nurses at this time was low, less than one hundred in London, for example.

Summers describes home care of the sick in the nineteenth century as "hidden from history" (1992:227). As previously stated, evangelicals were instrumental in providing some of the early district nursing schemes as part of their work, partly because of the suffering that they encountered when visiting the poor, but also as means of encouraging them to adopt a more Christian way of life. For example when a patient was taken off a bible nurse's books, a bible woman visited to induce her to subscribe to the bible and to attend a mothers' meeting. Other religious charities were influential in the development of domiciliary nursing in the nineteenth century, and this development also had a role in the changes that took place in hospital nursing.

In Britain two nursing charities, the Institution for Nursing Sisters, Devonshire Square (founded in 1840 by Elizabeth Fry), and St. John's House, can be used to demonstrate how this occurred, and suggest that reform in nursing predated the Nightingale reforms by some twelve years. District visiting by these and other Bible charities (from which we get the term 'district nurse') was "an attempt to recreate the social relations of the rural parish in a period of rapid urbanisation" (Summers 1991:134). Moreover, it was seen to prevent the 'deserving poor' from decline into poverty because of the long term sickness of the breadwinner, thereby increasing self reliance. It was seen by Victorian philanthropists as a moral obligation to aid the deserving poor in a spirit of mutual self interest.

> The poor would come to see their true community of interest with the rich, a truth hidden from them when they were surrounded by filth, immersed in drunkenness and 'sensuality', ill educated, ignorant of religion and deprived of a proper family life ... Humanitarianism was, in this

> sense, the other face of coercion. (Donajgrodski 1977 p59-60)

The issues of Victorian philanthropy, and social control will be addressed at more length in chapters 5 and 7 respectively.

At the same time there was an interest in reviving the sisterhoods in the Protestant church and in regaining the influence of the Protestant church over the voluntary hospitals, and attending the sick poor provided a vehicle for these developments. In order to finance and expand their charity work, both St. John's House and the Institution for Nursing Sisters provided private nurses to the wealthy, and most nurses would undertake both types of work - charity and fee paying, although many openly preferred private work. Before being admitted to the sisterhood a probationary training in one of the voluntary hospitals was undertaken, and each nurse had to provide written testimonials (they would not otherwise have been acceptable to fee paying patients). These nurses soon achieved a reputation as a reliable source of labour, and voluntary hospitals began approaching the institutions for supernumerary nurses and supervisory staff. Summers (1991) maintains that, as they moved between the voluntary hospitals and the homes of the wealthy, the sisters were very critical of institutional care. In one example that she cites, nurses from the Institute of Nursing Sisters who were employed at the London Hospital "threatened to leave because it was so dirty" (Summers 1991:142). The standards of care which were expected by the wealthy who were paying for private nursing, such as cleanliness, good cookery, night nursing and technical skills, were maintained and delivered to the poor by the sisters in institutions. In 1875 the

Report of the Metropolitan Association commented that St. John's House had done much to raise the standard of nursing.[18]

Summers contends that poor patients, who lost out when financial considerations forced the sisterhoods to take more domiciliary paying patients, gained when their skills were transferred to institutions:

> It was not the increasing sophistication of medical and surgical procedures which led to the call for better trained and disciplined nursing staff, but the perception of the urban poor as beings in need of spiritual ministry. Nursing sisterhoods sent their members to hospitals to gain experience of a large variety of cases in the space of a few weeks; not because the hospitals themselves set standards of excellence. It was in the homes of the rich, rather than the hospitals of the poor that the demand for higher technical standards of sick nursing emerged. (Summers 1991:144)

It must be acknowledged, however, that Fry and her nurses did not set out to reform hospital nurses, but to learn from established practice. That the standards that were developed by St. John's nurses influenced hospital practice was incidental (Williams, 1980).

The influence of private nursing in the reform of hospital nursing was recognised by at least one nurse historian as early as 1897. Miss Breay (discussed above) describes it as the "Pioneer department of the Profession" (Williams 1980:494), as the presence of private nurses led to better nursing of hospital patients.

Nurses were also employed by Boards of Health (especially during epidemics), and poor law institutions for district nursing. As the Poor Law was

administered at the level of the parish it was likely that poor law nursing was fragmented, diverse and poorly recorded.[19] Summers (1992) suggests that because poor law nurses were not always paid in wages, they were as unlikely as other domiciliary nurses to appear in documentation. As will be discussed in chapter 5, census data are not useful in trying to elucidate the number of employed women, and tend to be an underestimate.

As early as 1843, in the Fifth Annual Report of the Registrar General, Farr expressed concern at the number of deaths occurring from puerperal fever, and recommended the training of nurses and midwives in London and large towns. He also advocated the appointment of trained parish nurses under the control of the Poor Law medical officer, as diseases of the poor were aggravated by lack of good nursing care (Hodgkinson 1967).

In 1854, in an address to the Epidemiological Society, Dr. Edward Sieveking[20] proposed that "suitable inmates of England's workhouses be trained in nursing so that they could go outside the workhouse and do nursing among the poor" (quoted in Anderson 1948:418). His idea was that workhouses should undertake this national provision as the religious institutions were too fragmented, and charities could not practically undertake a national scheme. Although the scheme would be costly, the idea was to stop families being a burden on the poor rate because of prolonged illness of the breadwinner. He also suggested that some of the money the family saved (presumably through not paying for care, and by returning to work more quickly) could be paid to the nurse as a bonus, thereby increasing her independence. Sieveking hoped that this would encourage respectable women from outside the workhouse to enter nursing, increasing the nursing workforce, which would then be available

to all social classes (Anderson 1948). Sieveking had first published similar ideas in 1849, when he had suggested that a committee of ladies be established to organise the district work, and that the nurses trained under the scheme be available to all, with payment being determined by means.[21]

A committee was appointed to consider "the question of supplying the labouring classes throughout the country with nurses in epidemic and other diseases, and during the period of childbirth" (Ogle 1874:395). The scheme was opposed by many with conflicting interests, including reformers such as Twining, who wished to reform the care of the sick within the workhouse, and others who thought that any remuneration of workhouse inmates would immediately be spent on whiskey. The scheme was, however, supported by workhouse masters and matrons (Ogle 1874). Probably the biggest obstacle was the state of the poor law medical service at that time, which could not have organised and administered such a large scheme, and the fact that the workhouse population from whom nurses for training would have been drawn was not static, with people entering and leaving regularly and repeatedly.

Although this scheme did not get established, and the workhouse visiting societies of people like Twining received more public attention, Sieveking remained committed to the idea of providing trained nurses for the sick poor. Anderson suggests that Rathbone, credited with developing the first district nursing service in Liverpool in 1859, may have been influenced, at least in part, by Sieveking's ideas. Having seen his own ideas rejected, Sieveking later became a staunch supporter of the work of the Metropolitan Association. Ogle, too, states that the public debate that took place over the scheme was influential in "preparing the general mind for entertaining the views now so

freely accepted as to the necessity of providing good nurses for the indigent sick" (Ogle, 1874:396).

The use of nurses in epidemics as visitors to the poor has been interpreted by Dean and Bolton (1980:93) as instrumental in placing them "as a valuable part of the management of the population in later times". The nurse had a social control function in ensuring that the behaviour of the sick person and his/her family neither prevented recovery nor spread infection, thereby setting a precedent for a system of inspection and surveillance which became accepted practice. Dean and Bolton argue that nursing reform, with its emphasis on improved sanitation and hygiene, needs to be viewed as the individual level of the discourse on poverty and the administration of the sick poor.

Apart from the organised district nursing associations, discussed above, many domiciliary nurses worked in an independent, autonomous way and provided nursing, and sometimes midwifery care, to all classes of people. Because few records survive regarding these nurses, their reputation has been formed from contemporary literature and medical journals. These very partial accounts were written mainly by doctors, who saw domiciliary nurses as a threat to their living, or by literary figures interested in reforming nursing. Therefore dominant opinion has been, and to a large extent still is, one of dishonest, disreputable women, who often did more harm than good to their patients. Summers (1989) argues that the skills of these independent nurses were denigrated or ignored, and yet could be as expert as male medical practitioners. Rafferty (1995) points to the fear of the competition that they posed as being at the root of vilification campaigns. There is little evidence of the skill or expertise which existed among

domiciliary nurses, and being independent it is likely that they were highly heterogeneous. It could be that the poorest were used as representative in order to satisfy the agenda of medical practitioners. As will be seen throughout this thesis, medicine frequently constrained nursing for its own ends.

Conclusion

Nursing history has, in the past, been treated unproblematically, using a present-centred approach. The result for nursing has been a dominant version of history, with the lives of a few elite individuals and the deeds they accomplished forming a major part of the literature. Traditional nursing histories which emphasise the progression of nursing from the 'dark ages' of Sarah Gamp to the enlightenment of Florence Nightingale are atheoretical, and concentrate on agency at the expense of structure and process.

At the same time these histories have served a purpose in constructing a particular image of what nursing should be, which benefited those in the nineteenth century who wished to reform nursing, and continue as a model for the socialisation of students into a particular culture.

The focus for orthodox nursing history has been the hospital, neglecting the fact that most nursing work, both paid and unpaid took place in the home, thereby rendering domiciliary nursing *per se*, and its major influence on the development of hospital nursing invisible. Even Davies' seminal work *Rewriting Nursing History* concentrated mainly on institutional nursing. Conventional historiography has tended towards Whiggish interpretations. Even critical history leaves questions unanswered in terms of domiciliary nursing, which will be addressed here empirically and theoretically.

In order to address the problem of present-centredness, archive material on home nursing will be supplemented by a consideration of the economic and social changes which took place over the period under discussion, especially how they affected the lives of women. This will facilitate an investigation into the generation of source material, and allow for a comprehensive analysis of the development of the occupation.

In terms of a theoretical framework, critical histories have often utilised feminist theory in order to explain the evolution of a female occupation, nursing, subservient to the male occupation of medicine. Few nursing histories have utilised the sociology of occupations to analyse nursing history, and those that have concentrate on professionalisation. In terms of district nursing the literature does not explain its genesis. Why, over the course of the nineteenth century, did a formal occupation emerge from a series of *ad hoc* tasks, largely carried out informally? What were the features of, and changes within, nineteenth century society which facilitated the emergence of district nursing, and contributed to its structure?

The occupation that did emerge was highly diverse, with individual associations having their own structures and working practices. Yet there also remained the independent and autonomous practitioners often vilified in contemporary literature. Why did this diversity persist, and what effect did it have on the process of development and professionalisation of district nursing?

Most district nursing associations separated out the functions of nursing, organisation, supervision, and fund-raising, usually along gender and social class lines. Functions were also divided between those which were paid and

those which were voluntary. This, then, raises questions of what constitutes work, and when does work become occupation?

Separating sociological concepts of 'work', 'occupation' and 'professionalisation' should allow for explanations to these questions to be formulated. Concentrating on the concept of professionalisation alone would not provide a sensitive enough instrument for analysis of all these issues, or an original approach to the emergence of district nursing.

Notes

[1] Debates surrounding attrition rates, and rostered service continue to rage in nursing.

[2] British Library (BL) add. Ms. 47719 f122 28.08.1875

[3] See Moore (1988) for examples from the Lancet and the Times.

[4] Witz (1992), Rafferty (1996) are among the exceptions.

[5] This was founded by high church Anglicans in 1848, and was better known as St. John's House. It is discussed in detail in chapter 6.

[6] Derby Studies Centre A610.73 Annual Report 1870/1:6

[7] London Metropolitan Archive (LMA) H1/ST/SJ/A33 Annual Report 1857:18

[8] Another response, attempts to control district nursing work will be discussed in chapter 7.

[9] LMA H1/ST/NC/15 13a & b Renamed first the Metropolitan and National Association for Providing Trained Nurses for the Sick Poor, then the Metropolitan and National Nursing Association, and in this thesis called the Metropolitan Association.

[10] The notion of the sexual division of labour being defined as task distribution by gender, while ignoring existing power relationships, is particularly pertinent to the development of district nursing, and will be a recurring theme of this thesis.

[11] The hierarchy of St. John's House is described in chapter 6.

[12] This concept is explored in chapter 2.

[13] LMA A/RNY104 Missing Link 1868:131

[14] Known as the Ranyard Mission, after its founder, Ellen Ranyard.

[15] LMA A/RNY104 Missing Link 1868:33

[16] ibid:133

[17] The implications of this for historical research will be explored in the next chapter.

[18] LMA H1/ST/NC/15 13a & b Report of the sub-committee of reference and enquiry on district nurses in London

[19] Although domiciliary nursing initiatives by some poor law unions did exist, they are beyond the scope of this thesis, and no systematic attempt to create a poor law district nursing attempt ever became established.

[20] Edward Sieveking was a founder member of the Epidemiological Society, and an expert on the Poor Law.

[21] BL 8275 cc 23 Sieveking E (1849) 'The training institutions for nurses and the workhouses: an attempt to solve one of the social problems of the present day.'

CHAPTER 2

The use of historical data as research method

Introduction

This thesis utilises historical data in the form of personal letters, documents and published journals, and annual reports relating to domiciliary nursing between c1840 and c1900 in order to construct a more salient account than those currently available. This chapter will explore methodological issues in relation to the use of such documents, and also to the use of historical data in terms of reconstructing the past from the standpoint of the present, the present-centredness referred to in the last chapter.

Researching history

Abrams (1982:1) states that serious questions about the contemporary world cannot adequately be answered without reference to history. "That the present needs to be understood as a product of the past is [an idea] that we have come to take for granted". He adds that although we cannot directly observe structure and process, these may be inferred from the observation of events. In traditional nursing histories (e.g. Masson 1985) these events are treated atheoretically and without reference to structure or process, purely concentrating on agency. Davies (1980:13) describes conventional history as a "broad brush overview" in which history is presented as a "narrative of events" (12) and where issues of theory and method are left unstated.

Much nursing history conforms to a Whig interpretation of history, described by Butterfield (1931) as the steady march of progress. A characteristic of this is an over-dramatisation of the story, with a consequent lack of regard for the historical process. Whig history, with a triumphalist approach of (usually) 'great men' carrying out 'great deeds', views the past from the standpoint of the present, and subordinates the past to the present. Another feature is abstracting events from their historical context and judging them apart from their context:

> [The Whig historian's] concern with the sphere of morality forms in fact, the extreme point in his desire to make judgements of value, and to count them as the verdict of history (Butterfield 1931:107).

Butterfield also points to the reference of the past to the present as leading to the classification of historical persons into those who furthered progress, and those who tried to hinder it, as well as leading to the search for likenesses to the present rather than differences. Those figures who are more analogous to the present will be more sympathetically treated.

Carr (1961) states that a positivist view of history as facts from which conclusions can be drawn, fits the British tradition of empiricism. Facts in this paradigm are external to, and separate from the historian, and independent of interpretation. Here, 'interpretation' refers not only to that by the historian, but also to what was considered significant and therefore selected by the chroniclers of the time.

Carr (1961:12) also differentiates between "facts about the past" and "facts of history". "The process of reconstitution governs the selection and interpretation of the facts: this, indeed, is what makes them historical facts" (22). Therefore, when consulting a work of history, the first concern should be with the historian who wrote it, rather than the facts that it contains. This thesis is concerned with district nursing, and to a lesser extent private duty nursing, in the nineteenth century, a hitherto neglected aspect of nursing history. It has been argued in chapter 1 that domiciliary nursing was not considered significant by previous chroniclers, who were for the most part concerned with the evolution of hospital nursing, as this is generally thought to be the most important influence on nursing development. It could further be argued that the dominance of histories of voluntary hospitals, and the scientific progress made by their doctors, conforms to a Whig interpretation of history. By publicising district nursing I am attempting to alter its status from facts about the past to that of historical facts. Scott (1988) argues that challenging received interpretation of progress is a strategy associated with 'her-story', an attempt to make women's experience visible and valuable. This also seeks to examine the structures of the lives of ordinary women, an approach that this thesis intends to adopt by including, where available, the experience of working class nurses, as well as the organisers and supervisors of district nursing schemes. These were, however, often mediated through a third party, usually a supervisor, so that their validity is questionable.

Carr, in continuing to give explanation by differentiation, cites Lee Benson drawing on E.M. Forster to distinguish between 'story' and 'plot'; a story being a chronological narrative, while a plot is a narrative that focuses on

causality. The historian, unlike the chronicler, is a 'plot-teller'. Butterfield (1931) treats this idea problematically as, in a historical context, the complexity of interactions may be telescoped into a single progression, often ignoring the intervening period, which then makes an attribution of cause a simplification of the issues. "It is all the more easy to impute historical change to some palpable and direct agency. What we call 'causes' are made to operate with astonishing immediacy" (Butterfield 1931:50).

Wilson and Ashplant (1988) argue that although Butterfield's thesis has become uncritically accepted by historians, his very success has masked a failure to define the nature and cause of the anachronistic writing he identifies, with a consequent lack of solutions. They perceive the root of this anachronism to be present-centredness:

> That is, that the historian, in seeking to study, reconstruct and write about the past, is constrained by necessarily starting from the perceptual and conceptual categories of the present. (Ashplant and Wilson 1988:253)

This is characterised by a probable disjunction between the "category-systems" (Wilson and Ashplant 1988:13) of the past and the present, and by the discrepancy between the historian's intended use of a source and the use for which it came into being. Whig history is one, but not the sole, example of the problem. Webb et al. (1984:114), for example, view archive material as problematic arguing that researchers have "little choice but to use what is available and then to apply corrections", implying a superiority for twentieth century knowledge.

Ashplant and Wilson (1988:268) propose a solution consisting of "explicit *investigation* of *the process by which the historical source was generated*" (original emphasis). This can be achieved by searching for internal clues or by consulting other sources. The authors admit that the process is not new, but claim that until now it has not been theorised.

The interpretation of the facts that I present is governed by what was recorded by the writers of the letters, journals etc. which I consulted. Added to this are my own editing and interpretation of them, for as Abrams states "the historian *selects* significant details from the plethora of available detail" (1982:194). Webb et al. (1984:115) also recognise that "systematic biases exist among editors". One of the aims of selection in this thesis will be an attempt to locate data within a sociological analysis appropriate to the period, thereby reducing the problem of viewing the past from the standpoint of the present. An example of this will be a challenge to the image of Victorian middle class women as "leisurely, dependent, prudish, and boring" (Branca 1975:144), a stereotype which recent writers have questioned ever existed (Branca 1975; Williams 1987). The existence of this image has, however, been influential in the interpretation of the middle class woman's motives for philanthropic work. Tuchman (1994:311) states that:

> Sometimes one can discern meanings - or make historical generalisations - only with the help of a knowledgeable informant, a historical figure who has been in a position to gather reliable information.

Despite the intention to include domiciliary nurses' experiences in the thesis, for reasons that will be discussed in the following section, the 'reliable figures'

of this research are mainly the organisers of home nursing schemes, who would have had their own agendas and reasons for the focus of their writing. One, for example, used her writing in order to encourage donations to her organisation, and this needs to be remembered when interpreting her work.

Abrams (1982) identifies three types of concern that can be said to constitute historical sociology, all of which have relevance for this thesis, and encourage an investigation of source generation. First is the concern with the transition to industrialism. Industrial capitalism and urbanisation led to changes in living conditions and in social relationships between rich and poor that were motivating factors in the development of domiciliary nursing. It will be argued in chapter 3 that it was social, rather than technological changes that created the conditions in which district nursing could emerge.

Secondly, there is a concern to trace the pattern of freedom and constraint in the lives of individuals in their immediate environment. This is exemplified in this thesis by case studies of nurses visiting the homes of the poor, and proselytising specific views about religion and behaviour, which conformed to the values of the Victorian middle class. That these values also constrained those who espoused them will be demonstrated by consideration of the limited opportunities for a life beyond domesticity for middle class women. This also reflects Abram's (1982:7) third concern, the "underlying insistence" that sociology is concerned with the individual (who possesses his/her set of expectations, purposes and motives) and society, whose institutions, values and norms can be seen as a constraint. This thesis explores the position of women in Victorian society generally and more specifically as members of an emerging occupation, the role of philanthropy within their lives, and the relationship

between middle and working class women. The extent to which the stereotypical role was the reality for women will be discussed in the light of the role that some women played within the public sphere.

The use of archive material

The archive material used in this thesis comprises historical records and documents, magazines and personal letters. 'Records' and 'documents' have fairly loose common sense definitions, and are sometimes used interchangeably. Within the literature the two are differentiated in various ways. Hodder, for example, defines records as having a formal purpose, such as birth certificates and driving licences, and documents, which are more personal in nature and include letters and diaries. Documents, being closer to speech, "require more contextualised interpretation" (Hodder 1994:393). Denzin (1970) makes the distinction between public and private documents, public documents including newspapers and journals as well as records. To the classification of personal documents Burgess (1984) adds primary and secondary sources, and solicited and unsolicited accounts.

The most useful definition for this thesis is that of Blumer (1939:29), who uses the term 'human document' more generically to describe "an account of individual experience which reveals the individual's actions as a human agent and as a participant in social life." Human documents are primarily of five types: letters, life histories, intimate newspaper accounts, court records, and records of social agencies. Its appropriateness lies in the first and last categories being used here as the source data for interpretation and analysis, and the linking of structure and agency being a main theme of the thesis.

Blumer argues that records of social agencies are more formal and less intimate than letters, and so their meaning depends even more on interpretative theory which the researcher brings to bear on them. This is made difficult by their fragmentary nature, and so it is important to ensure adequacy.

He further argues that documentary sources can be subjected to test considerations of representativeness, adequacy, reliability, and validity of interpretation, which may be strengthened by the use of multiple sources.

Other writers point to limitations in the use of historical documents. Webb et al. (1984) state that the problem of inaccuracies or unrepresentative accounts can be a major one, but can be minimised by the use of multiple sources.

Derrida (1978) has shown that meaning does not reside in the text, but in the writing and reading of it. Hodder (1994) states that written documents are an artefact, and are capable of transmission, manipulation and alteration.

Hodder (1994:394) adds

> As the text is reread in different contexts it is given new meanings, often contradictory and always socially embedded. Thus there is no 'original' or 'true' meaning of a text outside specific historical contexts.

The use of inaccurate or unrepresentative accounts can, however, be viewed positively, as they can give insight into dominant values of the period under discussion. Tuchman (1994) demonstrates this by using a critique of Tilly & Scott (1978), who in *Women, Work and Family* cite a nineteenth century MP describing a visit to a cotton mill. He depicts the young female workers in it as typical of women in employment. This Tilly and Scott refute by the use of

cliometrics (the use of quantitative methods in history). Tuchman (1994:311), however asserts that:

> Tilly and Scott's cliometrics cannot refute aspects of standard historical interpretations: The elite clearly identified female employment with the textile industry, and elites behaved as if their interpretation were accurate. Their interpretation had consequences ... By debating women's employment as *though* work in the textile industry were ideal-typical the nineteenth century British elite constructed and acted on a version of reality that did not correspond to the conditions of working class women.

Tilly and Scott were concerned with the accuracy of the MP's statement, but Tuchman considered the wider social implications of it.

Webb et al. (1984) raise the issue of selective deposit and selective survival among archive material. Rafferty (1995:52) notes a "bias towards the preservation of evidence by those classes whose culture is mediated through the written rather than spoken word." This has led to the views of the detractors of early nurses being prominent, with the perspective of the nurses themselves rarely recorded, or, as noted above, mediated by a third party. This thesis is concerned with district nursing, yet much of the archive material is not written by nurses, but by their supervisors or their employers. Even record keeping was not always carried out by working class nurses, who were not considered to have adequate literacy skills, and so reports are usually secondary. Those nurses whose letters have survived were usually middle class women, therefore adding a social class dimension to the availability of data. Middle class nurses had longer and better training, they were unused to the type of homes that they were sent to, and would probably have had different

reasons for entering nursing than their working class counterparts. Their accounts of district nursing could not be said to be representative, since during the period under study over half the domiciliary nurses in London were 'respectable working women'.

The use of archive material is problematic in that we are constrained by what has been retained, and what we choose to retrieve. Interpretation can be coloured by present-centredness. Ideally texts can be used with other forms of evidence, so that the biases of each can be understood, or multiple sources can be utilised. This is the recommendation of many of the writers cited here. Interpretation of data needs to include an explanation of similarities and discrepancies between sources. Can similarities be used to generalise from the specific? Are discrepancies merely discribing special cases?

Biographical data

In writing about historical characters, albeit that some of those characters are anonymous, I am in Smith's words "writing lives" (1994:297). He adds that although contemporary sociologists have been ambivalent towards biography, this, in the form of life histories, became part of the methodology of the Chicago School with the publication of Shaw's *The Jack Roller* in 1930. Platt (1994), however, argues that much 'first hand' data attributed to it were actually initiated outside sociology, and the contribution of those collecting it has been played down. She also suggests that the extent to which the Chicago School relied on first hand data was exaggerated, and many accounts were written by third parties.

Some of the biographies in this thesis, as well as accounts of domiciliary nursing associations are taken from personal papers. At an ethical level, it could be argued that these papers were never intended for a wider audience than their recipients, and certainly not for the public arena. Some personal collections of documents do become public when they are published or bequeathed to museums etc., but this is not always the intention of the writer. In addition papers from one collection are being considered in conjunction with those from others, which at the time would not have been done. In other words I am creating a knowledge base that would have been unavailable to people referred to and quoted in the thesis, and as such my version of events may distort the reality of any or all of them. This is not meant to contradict my earlier comments on 'facts of history', merely to raise an ethical issue.

Ashplant and Wilson (1988) also acknowledge that the historian's use of sources is not the intended use of the original author. This is not perceived as an ethical, but rather as an epistemological problem, one that is overcome by an investigation of the source generating process.

These ethical issues are rarely discussed in methodology texts. Burgess (1984:123) states that documents are usually dealt with briefly despite the fact that "the world is full of documents that people write, send, keep, publish, display and screen". Even Burgess himself is not concerned with ethical considerations of the use of personal papers, but rather with categorisation of different sources, and with questions of "authenticity, distortion and deception, availability and sampling, and also presentation" (137).[1]

How can we justify the use of source material which could not be accessed if it were contemporary to us? Many libraries adopt the seventy five, or one

hundred year rule, by which no identification of individuals can occur until they are unlikely to be alive. In this thesis there is little identification of individuals, and many of those whose correspondence is used made their views known publicly during their lifetimes. The exception to this is Mary Cadbury, and I have limited use of her correspondence to descriptions of her district nursing work.

On a more positive note, Blumer (1939) states that the use of letters from different sources used collectively provides verification and support for the test of representativeness, adequacy and reliability, which can be viewed as of ethical as well as of methodological importance.

Smith (1994) states that the first task of a biographer is deciding on a figure to write about. When writing a thesis on a specific subject the figures, to a large extent, select themselves. It has to be remembered, however, that historical figures for whom information and personal papers are available are likely to be dominant, authority figures, rather than the 'silent majority'. In the case of domiciliary nursing the writings of Florence Nightingale are ubiquitous. This is because her writing was prolific, and her stature was such that her opinion on all nursing matters was widely sought. Both she and the recipients of her letters and pamphlets were able to retain them and perhaps realised their value. Following her death they were mostly brought together in one or two archives. This, however, does not necessarily make Nightingale an authority on domiciliary nursing, but because of biographers' pre-occupation with the Nightingale School and the general accessibility of her papers, a certain version of domiciliary nursing's place in nursing history may have become dominant. Other important historical figures do not figure so prominently in archive

material, particularly the nurses themselves, for reasons discussed above. Their omission could have lead a reinforcement of dominant descriptions of how domiciliary nursing was experienced, both by the nurses and by the patients. Smith (1994) states that prosopography, or group biography, leads to insight into these problems. First, because the private papers of prominent people give a different perspective on events than do publications and speeches, as do the people who surround them. Secondly, the study of group biography gives insight into the larger problems of social structure and social mobility. This is consistent with an investigation of source generation processes (Wilson and Ashplant 1988). Thus the papers of Nightingale can be supplemented with those of Bonham-Carter, with whom she corresponded regularly, the people who developed and ran district nursing schemes, and those nurses, and others, whose private correspondence also survives.

Researching district nursing

This thesis utilises primary sources in the form of personal letters, mainly from the Nightingale collection in the British Library, the Bonham Carter collection in the London Metropolitan Archive, and the Acland papers in the Bodleian Library. The major primary sources, however, are the annual reports, supervisors' reports, and journals published by district nursing associations themselves, and accessed in local town and county archives, the Wellcome Institute, the London Metropolitan Archive, the British Library, the Guildhall Library, and the Bodleian Library. Secondary sources used have comprised books and pamphlets published in the nineteenth century. It is argued that this

plurality of source material will conform to Blumer's test of representativeness, adequacy and reliability.

Three Protestant nursing sisterhoods are discussed, as being among the earliest examples of domiciliary nursing associations. One of the first was the Institution of Nursing Sisters, Devonshire Square, founded in 1840 by Elizabeth Fry, which provided mainly private duty nurses in London, but also undertook some gratuitous work. The Training Institution for Nurses in Hospital, Families and the Poor (St John's House), which started in 1848, was the first association to be organised on church lines, and to offer more than a rudimentary training to its nurses, and, at least in the early years, provided more gratuitous nursing to the poor than the Institute of Nursing Sisters. The third of the Sisterhoods considered is the North London Deaconesses Institute, founded in 1861, which, more than the previous two, modelled itself on the Protestant Sisterhoods of Europe, and extended its work beyond nursing to school teaching and other work.

The evangelical movement was also interested in providing district nursing as part of its mission work, and the Ranyard Mission began in 1868 as an extension to its work visiting the poor of London to sell bibles. Evangelical charities espoused the doctrine of self help and thrift and, to a greater extent than the Sisterhoods, predominantly provided nursing and not relief to patients.

Most district nursing associations were secular, but based on broadly Christian principles. The Liverpool Nurses' Training School and Home (the Liverpool School), founded in 1859 by William Rathbone, is generally thought to be the first district nursing association, despite the existence of the Sisterhoods. Rathbone was strongly influenced by Nightingale in the organisation of the

Liverpool School, and like her thought that nursing was most suitable for tradesmen's daughters, or similar, but in later years was converted to the idea of nursing as an occupation for educated women.

District nursing associations began to spring up all over the country, mainly in large and medium sized towns during the 1860s and 1870s, but most were small localised affairs with only one or two nurses, a lady superintendent, and a committee which raised funds and managed the organisation. These were quite diverse, many provided private duty and district nursing, some would also provide midwifery services, and some would pay for nurses to be trained. The various organisational and working practices of the associations in Stratford-upon-Avon, Derbyshire, Leicester, Oxford, and Worcester are explored in this thesis.

In 1878 an attempt was made to bring some uniformity to district nursing, and to provide a national, trained district nursing service. This was initiated by the Metropolitan and National Nursing Association, which tried to impose a one year hospital training plus an additional six months district training. In this the views of its first Secretary General, Florence Lees,[2] dominated. She also wanted to improve the status of nursing by employing only educated ladies, and providing only nursing care to the sick poor.

Towards the end of the century organisations for the affiliation of nursing associations began to emerge, and three of these will be discussed. The Queen Victoria's Jubilee Institute for Nurses (Queen's Institute) was formed using money from a Golden Jubilee appeal, in order to affiliate associations whose nurses conformed in training and standards set out by the Institute. Like the Metropolitan Association, which became its main training institution, the

Queen's Institute wished to raise the status of nursing, and to attract educated women into district nursing.

While associations were being developed in towns, rural areas were also perceiving a need for district nurses, but saw their own circumstances as different from those in urban areas. The other two organisations for affiliation discussed here were both set up for nursing associations in county and rural areas, the Cottage Benefit Nursing Association[3], begun in 1883 by Bertha Broadwood as a provident association, and the Rural Nursing Association, started in 1889 by Elizabeth Malleson. Broadwood and Malleson, however, had quite different views about what the special needs of rural areas were.

The analytical framework for the examination of these associations are sociological theories of work, occupation and professionalisation, with occupation being proposed as the most crucial. These concepts will be explored in the next chapter. Also of major importance are issues of gender and social class, the gendered and hierarchical division of labour, as experienced in the nineteenth century, being influential in the way in which the occupation of district nursing developed.

When researching the nineteenth century, concepts such as public and private sphere, home and work, production and consumption, are often used as dichotomous terms. It is not the intention here to construct dualisms, but in order to achieve clarity of analysis, this may appear to be the case. Boundaries are fluid, with much overlap, and people in the nineteenth century would not have conceived of these concepts, which are twentieth century categorisations, as dichotomous.

Conclusion

This chapter has discussed some of the methodological issues surrounding historical research, and given a rationale for the approach adopted in this thesis. It was shown in chapter 1 that even critical accounts of nursing history were dominated by the history of hospitals. Researching archives of district nursing associations is an attempt to acknowledge the significance of domiciliary nursing in the development of nursing.

These methodological issues can be viewed as researcher problems, data problems, and ethical issues.

Researchers need to avoid the pitfall of present-centredness, by investigating the generation of source material. This I propose to do by an analysis of the social context in which it was constructed, at both a macro and a micro sociological level. The problem of selective retrieval will be addressed by the consultation of multiple sources.

Potential limitations in the data centre around selective retention and unrepresentative accounts. The bias towards the preservation of written text was unavoidable given the technology available at the time, but can be reduced by the consultation of multiple sources, and other forms of evidence.

Ethical problems are concerned with the use of data, albeit in the public domain, which was not intended by the author. Researchers have a responsibility to strive to maintain the integrity of the text, and this can best be achieved by adopting a sympathetic understanding of the context in which it was written.

In summary, the consultation of multiple sources and forms of evidence, and an analysis of the social context in which it was generated will be used as a check for representativeness, adequacy and reliability of individual accounts.

The problems of historical research are, however, balanced by the richness of individual experience it is possible to obtain by the use of personal papers and historical documents. The present is a product of the past, and the past consists of its agents as well as its structure and institutions. As Blumer (1939:51-2) states:

> Human documents are the device by which one may reach the actual human experiences and attitudes which constitute the full, live and active social reality. .... The document may be thought of as preserving the experience.

Notes

[1] I do not mean to imply here that Burgess is not concerned with research ethics, merely that he has not identified the ethical issue that I am raising.

[2] Florence Lees, pupil of Florence Nightingale and first superintendent of the Metropolitan Association, later became Mrs Dacre Craven, under which name she published a book on district nursing. For clarity, the name Florence Lees will be used throughout the text, but the book will of course be correctly referenced.

[3] Often called the Holt-Ockley system after the areas of Norfolk and Sussex where it originated.

CHAPTER 3

Occupations, professionalisation and domiciliary nursing

Introduction

This chapter will discuss some of the more frequently cited work on profession and occupation (acknowledging that much work on the sociology of professions is more usefully viewed as sociology of occupations), and consider its applicability to the development of home nursing. It will also introduce the concept of gender as a relevant factor in the genesis and development of occupations, since, as Witz (1992) and Davies (1996) have argued, the relationship between gender and professionalisation has been a neglected area in the sociology of professionalisation.

Freidson (1996:3) states that "a profession is a kind of occupation and the generic activity of an occupation is work", so in considering the emergence and development of an occupation, the concepts of 'work', 'occupation', and 'professionalisation' need to be addressed problematically, and the occupation in question viewed not in isolation, but having regard for its relationships with other occupations. There are also issues around the question of when work becomes an occupation, and what the sociology of professions and professionalisation can offer as an analytical framework for the development of a particular occupation.

All professions, however well organised, however powerful they appear now, had to start somewhere. What is seen from the standpoint of the twentieth

century as an occupation which has succeeded in a planned attempt to control a segment of the labour market is, very often, a story of order out of chaos. The more established occupations have generally had more time to become ordered. That is not to say that time is the only criteria for the development of occupations - merely that in observing occupations from their situation at the present time, we are not doing justice to the complexity of the process of development, and cannot necessarily make observations about their genesis. The genesis of an occupation is important in understanding why and how it evolved in the way it did, yet much literature on professionalisation takes for granted the concept of 'occupation', using it as a starting point on the road to professionalisation, and not treating it as a problematic issue. As Freidson (1994:77) contends "what is generic to occupation - its existence as an organised form of differentiated productive activity - is at worst ignored and at best blurred and obscured by the analytic focus of both class and stratification theory." Roth (1974) also advocates an historical approach to the development of occupations, in order that it can be seen as a long term process of negotiation rather than the collection of certain attributes.

Freidson (1996:5) argues that even this is not extending our sphere of interest far enough:

> No theorizing about professions, (let alone other kinds of work) can address officially recognised work without considering officially unacknowledged work in the informal economy, if only because many professions have their origin in the informal economy and only later become recognised officially.

This idea will be developed in the next section.

To really understand modern professions it is necessary to consider the way in which the work became recognised as a paid occupation; were the same people responsible for carrying it out in the informal and official economy, what was the impetus for change, how did the occupation then develop in terms of capturing a market, and in its relationships with other occupations? These questions are pertinent to the study of district nursing, which was in the mid nineteenth century just emerging as a paid occupation, out of a set of tasks which for centuries had been carried out informally by women. To this day those tasks are undertaken in the private sphere as unwaged, and as waged in the public sphere.

Work and occupation

This thesis is predominantly concerned with the genesis and subsequent development of an occupation, and so it is important to consider what constitutes work, and when does that work become an occupation. As district nursing was an entirely female occupation, the emphasis of this section will be on women's work.

In Western society the current orthodoxy is to perceive work as paid employment, the preserve of the economically active. Grint (1991), however, argues that no objective, unambiguous definition is possible, and there is, moreover, no consensus about the meaning of work. According to Stacey (1981), classical theories were inadequate to analyse the part played by non-waged work in the social order, to appreciate use value as opposed to exchange value.

Freidson (1978:2) states that as official representations of the workforce do not include all who work it is necessary to:

> develop some realistic conception of the entire economy in which various occupations are practiced, an economy which extends past the boundaries delineated so arbitrarily by the official labour force.

This Freidson does by categorising the labour force into the official, informal, criminal and subjective. The official economy comprises those occupations which take place in the official market. Of particular interest here are the informal and the subjective economies, which will be described further.

Pahl (1984) states that around the end of the eighteenth century there was a shift from a world where wage labour was one of a variety of forms of work, to one where it was the only one of significance. This shift, with the simultaneous rise of the notion of the male breadwinner undermined the household as an economic unit, and led to a neglect of the work done outside the formal employment structure by women, with work of use value being disregarded. Chapter 2 illustrated the prevalent view of women workers as being employed in textiles. Pahl, however, points out that despite the importance of women in the textile industry, dressmakers, who worked mainly from home, outnumbered textile workers by two to one in 1870. Even where women were not constantly employed, it was often necessary for them to work periodically for wages, either in their homes or in other places. This conforms to Freidson's category of the informal economy, in that it was largely unregistered, and could be performed for money, but also for barter. Women's domestic work inside the

home, as well as their wage earning activities would fall within the concept of the informal economy.

Hakim (1980) has noted the frequent overlap between domestic work in the home and other forms of work, for example taking in washing, child minding, or taking lodgers, this being the least disruptive way for women to earn a wage, as it could be fitted in with domestic responsibilities (Alexander 1976). Work which had use value could be carried out simultaneously with work of exchange value. The main beneficiaries of this arrangement, however, were husband and children, as the wife worked what has come to be known as 'the double shift'.

Grint (1991:11) notes that "there are very few activities undertaken outside a pecuniary relationship which do not take place within one." Women who were involved in their husband's business were unlikely to record an occupation in census returns, so that the work of a married woman was hidden behind that of her husband (Alexander 1976). Problems such as these lead to the conclusion that the notion of waged work is not comprehensive enough to encompass the range and diversity of female occupation and employment.

It could be argued, then, that the rise of capitalism disrupted male patterns of work more than female ones. Much recorded evidence of female working is that of single women, as women often left the official labour force on marriage. Pahl (1984:64) comments "Perhaps the best way to view women's employment in the nineteenth century is as the employment of *daughters* but not mothers". He adds that this led women to view employment as temporary and engendered a feeling of short-termism. Grint (1991), however, describes married women as absent from visible, paid employment, rather than as not employed, and

Alexander (1976) argues that the labour historian has ignored women as workers. Pahl's argument is convincing up to a point, but conforms to a patriarchal notion of paid work only taking place in a formal workplace, and ignores the existence of the informal economy. Also, prevailing mortality rates meant that there was a large number of widows in Victorian England, many of whom needed to earn their living. Hakim (1980) reports that two thirds of widows recorded an occupation in censuses after 1851. Widows featured strongly in the overlap between domestic and waged work, but they were also present in workplaces outside the home. Little is known about where district nurses came from, but the literature does provide some clues, including on marital status.

St. John's House named nurses in its reports, and a number were titled 'Mrs'. As the nurses lived in a central home, these were likely to have been widows. Florence Lees in communication with Florence Nightingale often named nurses, again many were titled 'Mrs', and at one point she wrote of a Mrs Long, who was a widow about to remarry.[1] Bertha Broadwood's first cottage nurse was "a respectable widow."[2] Associations seemed to rely on local clergy, or committee members to recommend suitable, respectable women to undertake training as district nurses. Most stipulated women of between 25 and 40 years of age if they were to undertake training, and within this age group some were likely to have been widows. In analysing domiciliary nursing in nineteenth century Edinburgh, Mortimer (1997) found that most were either widowed or unmarried, and included a number of older women.

Grint states that work is a social, not an individual activity, and Pahl adds that work cannot be viewed outside its social context. Any task can be labelled

'work', but social relations will define it as such. Pahl argues that the exclusion of married women from the workforce was the result of policies employed by paternalistic employers concerned about family life, but Grint points out that this coincided with the material and patriarchal interests of male workers. He further argues that the exclusion of women only occurred where male interest was sufficient to eject women. Nursing, it has been argued, was designated as 'naturally' women's work, an extension of domestic labour into the public sphere. Male interest, as will be seen in subsequent chapters, was limited to control of nurses' work and behaviour.[3]

Freidson (1994) comments on the social relations of 'task'. The same set of tasks can be practised in a variety of settings, in which the social contingencies of task can vary, as can the actual substance of tasks chosen from the potential repertoire. The relevance of this for domiciliary nursing is illustrated in chapter 7 by a discussion on the training and supervision of district nurses, the work carried out, and their relationship with private duty nurses. This will also highlight the heterogeneity of domiciliary nursing, a recurring theme of this thesis. Freidson further argues that variations in the social contingency of task may be seen to influence the degree and type of shelter an occupation can obtain. This argument will be taken up in chapter 8.

The dominant view of work as paid employment is too narrow to encompass all the activities involved in district nursing. The nurses providing direct clinical care were mainly paid employees, but there were exceptions. North London Deaconesses, for example, were expected to contribute a sizeable portion of any income they possessed to the Institute. At St. John's House, the nurses were paid, but the Sisters were expected to contribute an annual sum to the

institution. It was this, rather than the work carried out which formed the basis of hierarchical divisions within Sisterhoods.

Freidson's (1994) distinction between professional and amateur, where a professional performs tasks in a contracted market exchange would not adequately describe this situation, as relationship to the market was not the defining feature. Besides, Horobin (1983) points to the problematic nature of defining amateur activities as not having a market value. Freidson's categorisation of the subjective economy, however, provides a useful analytical tool. The subjective labour force is that which does not gain subsistence from its work, yet does produce goods and services of value, and is therefore analogous to Stacey's (1981) concept of use value work. The gain for the worker, if any, is symbolic. Freidson states that once we forsake market exchange criteria, it is difficult to discriminate between work and leisure, but the example of domiciliary nursing provided by Sisterhoods, discussed in chapter 6, demonstrates a clear distinction.

Workers in the subjective labour force need some connection to the official economy in order to gain subsistence, and for many this is via a form of paid work. For nineteenth century philanthropists, however, this only held true for some, for instance the doctors and clergymen who were prominent on many district nursing association committees. Some male philanthropists had other forms of income. Rathbone, for example, had sufficient income from the family business to allow him to spend most of his time in subjective labour, on committees such as the Council of the Queen's Institute and as a Member of Parliament. The Duke of Westminster, trustee of the Metropolitan Association, had inherited wealth. For the lady superintendents, their husbands' position and

status involved their wives not being in the official labour force, and they therefore received what Freidson (1990:158) called "domestic patronage." Volunteer work is included as an important part of the subjective economy, the work often being essential to society, the people involved highly productive. Freidson (1978) points out that many occupations in the official economy of industrialised countries grew out of volunteer work, so that voluntary work can be the germ of official occupations.[4] Similarly, Prochaska (1980) argued that involvement in philanthropic work paved the way for women's acceptance as paid officials, and this idea will be addressed in chapter 8, with a discussion of the move from volunteer to paid superintendence of district nurses. Whether the same women were involved in the paid occupation as the unpaid is difficult to ascertain, but the intention of those wishing to create a profession for middle class women was that they should be drawn from the same class.

In district nursing associations, lady superintendents often devoted a great deal of time to their work, and amassed knowledge and skill, but were unpaid. So were committee members who made financial and policy decisions, and towards the end of the century were influential in shaping the future structure and organisation of district nursing. Lady volunteers raised much of the funding, both to finance the associations and to provide medical supplies and comforts, and in some cases actual relief, for patients.[5] Prochaska (1980) points out that although this philanthropic work by women is a matter of record, the role of women as contributors to societies is not. Again the issue of leisure arises, and Freidson (1994) acknowledges that there is a problem in knowing how to define such tasks as productive labour, rather than leisure activities. Grint (1991), however, argues that work cannot be distinguished from non

work, by defining non work as leisure. What is a leisure activity for some, such as playing sport, is a paid occupation for others, and can therefore be located in either the official or the subjective economy.

Domiciliary nursing was located between the separating spheres of private and public labour, carrying out paid work in domestic settings, and as such had to negotiate the tension between the two. This was particularly true of private duty nursing, where the nurse lived in the home of the patient. Stacey (1981) argues that many of what she calls people-work activities transferred from the private to the public arena, and from the unwaged to the waged sector, as the latter became increasingly invasive and dominant.

Could only the paid nurses, and not the volunteers be defined as 'working'? A more appropriate view of work in this situation would be one where time and effort spent, and skill in providing a service are the defining features, not the existence of monetary reward, thereby acknowledging other contributions to district nursing associations.

For the work carried out to be considered as an occupation, however, market exchange is necessary, plus a general acceptance or official recognition that certain work constitutes an occupation.

Freidson (1994) states that occupation represents too critical a concept in sociology to be taken for granted, as it represents the productive activities upon which societies are based. It also has the potential to link the macrosociological world of social structure with the microsociological world of everyday experience.

> Without such linkage we might be able to understand how work gets organised in a general and formal way, but we could not understand

> how and why it gets done in a particular way; we could chart how an occupation is organised formally, but we could not understand the source and nature of the cleavages and threats that weaken that organisation, nor could we link occupation to the everyday experiences of its members. (Freidson 1994:86)

This is particularly relevant to occupations like domiciliary nursing, which in the nineteenth century were heterogeneous, and at different stages of formality and professionalisation. Only by linking structures and everyday experience can that heterogeneity be explained and understood.

A useful way of studying occupations is to analyse, *inter alia,* the circumstances in which occupations become organised as social groups, and the degree of organisation. Also, to explain how and why their form of organisation came to be and could be maintained, and the consequences for the productive division of labour (Freidson 1994). For Freidson, although he recognises its problematic nature, task forms the link between organisation and experience, but in considering the heterogeneity of district nursing I believe that the practitioners, and other actors such as lady superintendents, also hold a key to satisfactory explanation. What tasks constituted district nursing, who carried them out, and who employed them?

Professions and professionalisation[6]

The remainder of this chapter will address sociological perspectives on professions and professionalisation, as this is the area on which most sociological analysis to date has concentrated. Some aspects of previous work, such as knowledge base and education are, in any event, equally relevant to a

study of occupations. I will begin with a brief overview of the sociological work of the 1950s before moving on to the critique that characterised the writing of the 1970s and later, which is my main focus. Although I accept that there is a reappraisal of functionalism present in modern scholarship (Halliday 1987, Saks 1998), this is not my concern, as it was not a reading that was available to its 1970s critics. The interpretation which I present here is that most commonly used by those neo-Weberians whose work is to follow, as a starting point for their own thinking.

Functionalist writers tended to emphasise the functional characteristics of professions, such as altruism, neutrality or disinterestedness. Parsons (1954:34) considers that "Many of the most important features of our society are to a considerable extent dependent on the smooth functioning of the professions". He stresses the role of rationality in modern professions, rationality that is institutional and part of a normative pattern. The exercise of authority is based not on a generally superior status, but on superior technical competence. The inevitability of this appears to be somewhat taken for granted by Parsons, who uses the medical profession to describe the functional specificity of professions, the importance of which he believes has been obscured by the focus on self interest. "A professional man is held to be 'an authority' only in his own field" (Parsons 1954:38).

He also places great importance on "collectivity orientation", the ideology of placing the interest of the patient above self interest, and excluding the profit motive from actions taken in the professional role. He does, however, question the characterisation of disinterested professions in an acquisitive free enterprise economy. The fact that professions have developed successfully in the same

society as a business economy suggests that it is too simplistic a view, and there may be elements common to both areas.

Work from the 1950s which concentrates on a trait approach tends to accept the definitions and values espoused by the profession itself, and therefore stresses attributes such as public service, altruism, and an ethical code. This approach, which emphasises the positive functions and achievements of professions, and the important role they play in society, has been widely criticised as being uncritical, and as viewing professions as a static concept.[7] Although trait and functionalist theories dominated the 1950s and 60s, as early as 1951 Hughes wrote:

> Let me only indicate that in my own studies I passed from the false question "Is this occupation a profession?" to the more fundamental one, "What are the circumstances in which the people in an occupation attempt to turn it into a profession, and themselves into professional people?" and "What are the steps by which they attempt to bring about identification with their valued model?" (Hughes 1971:340).

Hughes' interactionist approach moves away from the static, trait approach in which professions emerge as they gather more of the necessary attributes, towards a more dynamic, negotiated model, developed from observational studies of the workplace. The concepts of license formalised by the state, and mandate claimed by the profession itself are central to Hughes' work. Certain occupations claim an implicit or explicit license to carry out certain activities in exchange for money, goods or services, and the mandate to define for themselves and others the proper conduct over matters concerning their work.

Freidson (1994), too, regards it as more useful to take a theoretical stance towards the features which distinguish occupations in general, and the processes through which they develop, maintain themselves, grow and decline. Hughes (1971:377) discusses the emergence of new occupations from the development of a scientific or technical discovery which may be applied to the affairs of others, or from some change in society itself. There may be specialisation within an existing occupational group, that is occupational fissure or fragmentation. Private duty nurses, for example, often emerged from the ranks of the servants, and were not differentiated from them in the census until 1861 (Davies 1980). Dingwall (1983) also suggests that occupations change or emerge as a result of change in either social relations, or the material base, which creates a market gap.[8]

Hospital nursing can be seen to have evolved as a result of both of these processes, but domiciliary nursing, as the formalisation of tasks previously carried out by most women, cannot be said to be the result of technological change. Although there *may* have been a qualitative difference between formal and informal domiciliary nursing, the tasks performed were virtually the same. Why, then, did domiciliary nursing come to be seen as more appropriately *paid* work?

Nightingale recognised that the technological changes which were influencing the work of hospital nurses were not affecting domiciliary nursing. As she wrote in 1874 "The Hospital Nurse has all the newest and best Hospital appliances. Indeed, her duty is to have all these ready to hand, the District Nurses' duty to do without them."[9] What differentiated the hospital from the district nurse was the latter's ability to carry out nursing tasks with minimal

equipment, to influence the behaviour of the poor, and to be able to use her initiative in the absence of a doctor. As shall be shown later, these attributes comprised part of the rationale for exclusionary tactics undertaken by professionalising district nursing associations.

Monopoly and the professional project

Larson (1977) links the rise of professions to that of capitalism, and the competition for markets. She argues that the structure of professions results from two processes; organisation of a market for services, and collective mobility. Without a secure market, the process of mobility would have been meaningless.

Larson (1977:xvi) describes professionalisation as "the process by which producers of specialist services sought to constitute *and control* a market for their expertise" (original emphasis). It is therefore an attempt to translate one order of scarce resources (special knowledge and skills) into another (social and economic reward). She further argues that maintaining scarcity implies a tendency towards a dual monopoly - monopoly of expertise in the market, and monopoly of status in a system of stratification. The means of establishing monopoly is via the professional project, which is a strategy of occupational closure.

The task of professionalisers was to open the ranks of the traditional professional elites by an attack on their gatekeeping institutions, and to organise the expanded market opened by urbanisation and the rising living standards of the emergent middle classes. They had to create the market for

their services, to gain special status for their members (by the creation of new gatekeeping institutions), and to give them respectability.

The position of the professional middle class was improved almost solely by the organisational efforts of their own leaders and by the voluntary associations which acted against traditional monopolies over title and license, and also against competition from "disreputable colleagues" (Larson 1977:12). The incentive for loose organisational communities of independent producers of services to organise was the competition for prestige, which could be converted to monopolistic power. They were successful if they managed to outrank or eliminate competitors in the field, and also when they managed to obtain authority over related occupations. The medical profession is a very good example of this. As Loudon (1992:219) argues "The foundation of medical associations - especially the Provincial Medical and Surgical Association, the predecessor of the British Medical Association - are .... evidence of the birth of a new spirit of professional unity". He also points out that many of the changes that took place as the result of the efforts of such associations were for the nineteenth century practitioner "accompanied by a sense of disappointment and frustration" (221), highlighting the complex nature of professional progress. Professional work was becoming a full time occupation, subject to free market competition, so in order to protect livelihoods the new professionals had to produce homogeneous guarantees of competence, which they did by a claim to sole control of superior expertise.

In order to achieve this:

> *the producers themselves have to be produced*
> .... professionals must be adequately trained and socialized so as to provide recognizably distinct

> services for exchange on the professional market.
> (Larson 1977:14, original emphasis)

The middle classes were for the most part excluded from the traditional methods of gaining status - education in upper class schools and universities, and association with elite clients - so the bases for prestige had to be reconstructed in order to permit middle class access to status, and monopolisation of its benefits (Larson 1977:88).

The rewards for individual practitioners compensate for the social control of members by the professional organisation, and the main motivating factors for joining a collective project are, argues Larson (1977), fear of exclusion, and the maintenance of social distance from the unqualified. So although the project is collective, the aims are individualistic. Hughes (1971) perceives this as two kinds of professional mobility - first, individual, which is achieved by entering a profession of high prestige, or by achieving special success within it, and secondly, collective effort of the occupation to increase its power in relation to others.

The markets for professional services had to be created, as existing markets were diverse, and for one secure market to arise, its superiority over others had to be established. This was achieved by elimination of competing products in order to gain a monopoly over provision of a service. This monopoly was "monopoly of competence legitimised by officially sanctioned 'expertise', and a monopoly of credibility with the public" (Larson 1977:38). For this to occur the professional association had to be recognised by the state, and it was also

important that it was not challenged by another association with equal credibility.

Social mobility and market control are, then, the outcomes of professional projects, undertaken incorporating sources of prestige. These Larson schematically differentiates along three main dimensions:

1. The relation to the professional market: independent or dependent on an achieved market position. Larson argues that in the formative stage the means are independent of the market, but the situation changes as the market is established.
2. Modern or traditional: this distinguishes the *ancien régime* dependent on aristocratic sources of legitimation, and association with elite clients, from those professions attempting to formulate criteria of inclusion/exclusion on the basis of tested competence based on a professionally defined body of abstract knowledge.
3. Autonomous or heteronomous character of the means employed: autonomous are those where the professional group plays a major role, heteronomous are those defined or formed by other social groups.

Abbott (1988:316) views monopolist theorists as swinging the corrective pendulum too far in a reaction to the benignity of functionalism and rejects both:

> functionalism, with its naive reification of American society; or monopolism, with its equally naive fear of the dominant classes; or professionalization, with its wistful belief in a sort of corporatist nirvana.

In viewing functionalist and monopolistic theories as dichotomous, difficulties arise when attempting to explain the actions of individual practitioners. Professional organisations may appear to be structured in a such a way as to promote self interest, but practitioners may be seen to be acting altruistically, in the interests of their clients. Parsons (1954) points to the preoccupation with self interest as creating a false dichotomy between egoism and altruism. The problem is compounded by the fact that most discussion on altruism takes place at the level of individual clients, treating this as synonymous with public interest. Saks (1995:11) defines public interest as "the wider societal obligations of professions", which may or not coincide with the interest of clients. Similarly, Saks differentiates between a profession and its individual practitioners, a distinction which he says is crucial, as there is no inevitable relationship between the attitudes and behaviour of individual practitioners and the characteristics of the profession to which they belong.

In linking structure and agency, while still accepting them as two levels of analysis, it may be necessary to accept that an occupation can simultaneously act in its own self interest and adopt an altruistic stance towards clients. It could further be argued that the more developed an occupation, the further into the stage of established professionalism and the more protected the market shelter, the more likely it is to promote the needs of clients and values of altruism. Professions may be involved in many projects simultaneously, some of which may appear conflicting. In this thesis district nursing associations will be shown to demonstrate elements of altruism and self interest. Sisterhoods, for example, were concerned with opportunities for women to live independently of men, later associations sought to make district nursing a suitable job for

middle class women. For many this coincided with a strong desire to improve access to, and standards of, nursing care for patients. This will be explored in chapter 8.

Social closure

The concept of closure was developed by Weber[10] to describe strategies adopted in the face of competition for a livelihood, in order to exclude outsiders and create or maintain a monopoly (Weber 1968).

> This monopolisation is directed against competitors who share some positive or negative characteristics; its purpose is always the closure of social and economic opportunities to *outsiders*. .... [Monopolistic advantages] may remain open to all monopoly holders, who can therefore freely compete with one another. (Weber 1968:342, original emphasis)

Economic reward is normally the impetus for closure, but status and prestige are also relevant. The idea of 'vocation', which was seen as central to reformed nursing, meant, however, that monetary reward was of little concern to professionalising district nursing associations.[11] Status was what they were attempting to achieve for nursing by professionalising strategies.

The term 'labour market shelter' is preferred by Freidson (1994, 1996), who states that the shelter is sustained by credentialism, and that it is the possession of an accredited education and training. He regards the term 'social closure' as pejorative, as it implies that self protection by members is merely a conspiracy, without acknowledging the perspective of workers who are attempting to increase economic security, while continuing to practice the same work.

The concept of closure is expanded by Parkin (1979:45), to include the reaction of groups excluded by professional projects, which he calls "the other side of the social closure equation", and which he feels would link it more closely to Weber's contribution to stratification theory. He describes the actions of both dominant and subservient occupations in claiming and defending an area of work.

Exclusion and demarcation are both the use of power in a downward direction by dominant occupations. Exclusionary tactics include the use of entry qualifications (credentials), legislation or other means to restrict access, and define the boundaries of the occupation. They encompass a process of subordination, creating a group or stratum of inferiors, and are the dominant mode of closure.

Weber (1968:344) acknowledges that although efficient performance is of importance, the acquisition of qualifications is more concerned with "limiting the supply of candidates for the benefices and honors (*sic*) of a given occupation". Technical competence is, therefore, subordinated to restriction of entry. It can be argued that the two are not mutually exclusive as restriction of entry may be achieved by testing technical competence. However, "[c]redentialism stands out as an effective device for protecting the learned professions from the hazards of the marketplace" (Parkin 1979:56), and protects all but the most incompetent from variations in levels of ability, shielding the least competent from economic punishment.

Demarcation is concerned with the creation of boundaries between occupations, and a dominant occupation will use this to control and regulate the work of a related subordinate occupation, although it may also be

conducted on a more collegiate basis between occupations of equal status. A classic example of domination by demarcatory tactics was the limiting of the role of midwives in the late nineteenth century, thereby giving the medical profession complete control over childbirth. The Central Midwives Board created in 1902 was dominated by doctors, and did not have to contain any midwives. Demarcatory tactics were also used by doctors in the middle of the nineteenth century to control the work of district nurses, and to prevent them competing for the same markets. Later the Metropolitan Association and the Queen's Institute attempted to demarcate between their nurses and untrained, or partially trained, nurses. Demarcation, then, was an important facet in the development of district nursing, and these two examples will be examined later in the thesis.

Subordinate occupations may resist exclusionary pressure by countervailing social action, either usurpation, seeking inclusion within the structure of positions from which it is excluded, or dual closure. Usurpation attempts to accrue for the subordinate group some or all of the benefits of the dominant one. This may be achieved by minor reorganisation of the occupational tasks, or by complete expropriation (Parkin 1979). Usurpation, therefore, tries to exert power in an upward direction. Parkin notes an important distinction between exclusion and usurpation, which demonstrates the power differential between those who adopt these strategies. Rafferty (1996:42) states that:

> The new feminist inspired nursing elite which emerged from the first wave of nursing reform, looked to medicine for inspiration and patronage in developing a professional model of education for nursing.

So, although the medical profession had used exclusionary tactics against nurses, professionalising nurses looked to medicine as a model. The way in which this was reflected in district nursing education, and used as a professionalising strategy, will be discussed in chapter 8. Most branches of nursing allied themselves to scientific medicine in developing a more academic education, rather than with the feminist movement, whose aims would seem to have been comparable to those of the nurse reformers described by Rafferty. Whereas exclusionary tactics are often supported by legalistic strategies, usurpation usually relies on the mobilisation of support of members, and as such is liable to take place in a grey area between lawful and unlawful. Attempts at usurpation occur not only in the world of work, but may be adopted by any social group which wishes to seek inclusion in the institutions of civil society (i.e. women, people with disabilities, minority ethnic groups).

In adopting dual closure the subordinate group resists exclusion or demarcation from above, while simultaneously seeking to exert exclusionary tactics themselves to consolidate their own position. Using the example of the labour aristocracy in the nineteenth century, Parkin (1979) states that by monopolising the market in skills, it was better able to pursue usurpationary tactics against employers.

An occupational group may experience exploitation by exclusion from more dominant groups, while exploiting groups over whom it is dominant. "It is not, then, the social location of those who *initiate* collective action that determines whether the action is exploitative or not, but the location of those against whom it is directed" (Parkin 1979:90, original emphasis). The target of dual closure tactics, however, is not necessarily an identified one, but the

monopolisation of a market in order to effect usurpationary pressure may as a consequence reduce the bargaining power of another group.

In essence, dominant or powerful groups primarily gain resources by means of exclusion, while for subordinate ones the main strategy is usurpation, with occasional attempts at exclusion (Parkin 1979).

Parkin is not alone in preferring a Weberian to a Marxist analysis of exclusion[12], stating it to be less restrictive, because it encompasses relations of dominance and subjection other than those between capital and labour. Murphy (1984:550-1), however, sees a deficiency of closure theorists from Weber onwards as their "weak conception of the relationships among rules of closure and how such rules are structured", also as the lack of recognition given to societal differences in the primacy of some rules over others. He particularly criticises Parkin for failing to acknowledge the difference in the amount of power gained by credentials and that gained by property, viewing ownership of property as the principle form of exclusion, with all other forms being derivative or contingent on this. In this Murphy is reflecting the primacy given by Weber to power achieved by the ownership of property over that achieved by credentialism, but as Larson (1977) points out, the emerging middle classes in the nineteenth century were excluded from traditional methods of gaining status. Credentialism was, therefore the most effective route.

In a similar vein to Abbott's critique of monopoly theorists, Halliday (1987:3) criticises neo-Weberian theorists as being obsessed with the idea of professional self interest. In reacting against an "overly benign functionalism" they have swung the corrective pendulum too far, and the emphasis on

monopoly does not take cognisance of the breadth of collective professional influence, especially as it concerns the effectiveness of the state.

He states (1987:350) that:

> The impediment of vulgar monopolistic theories is that *one* consequence or even intent of professionalism becomes the raison d'être of the entire professionalization enterprise. The part is taken for the whole. Latent consequences become explicit intents; accompanying motives become sole bases of action. Results of professionalization are assumed to be the outcome of a professional "project." In a word the entire interpretative model is overdetermined.

Control of markets is only an issue during the formative stage of development, when a sphere of work has to be established. Halliday presents the example of the American legal profession, where the preoccupation with market dominance was one of the developmental stages in the emergence of the profession, and once its developmental tasks were completed its importance faded. What followed was a phase of "established professionalism", in which the professional tasks are different and a broader range of functions and actions are undertaken. "If it can secure its occupational niche and protect its vital economic interests, then a profession's resources can be freed from market concerns for other causes" (354). Saks (1998), however, argues that even if Halliday's analysis of the American legal profession supports the idea of reconstructing the image of professions, the legal profession, in view of its stronger link to state power, may be different from other professional groups in its fulfilment of the ideal of altruism. In other words, case studies of individual professions may not be representative of professions *per se*.

Witz (1992) states that little attention has been paid to the gendered politics of social closure by neo Weberian theorists, a situation that she attempts to rectify by her analysis of female professional projects. This is borne out by the fact that none of the works on closure so far cited mentions gender, except as contingent.

She further argues (1988:76) that "modes of patriarchal closure in the market place are generated and sustained by means of *gendered* strategies of exclusionary and demarcatory closure" (original emphasis). Gendered strategies of exclusion exclude women from routes of access to the resources necessary for entry into particular occupations. They are sustained by gendered strategies of demarcatory closure, which create and control gendered occupational boundaries in a division of labour.

In later work (Witz 1992) she takes the argument forward to consider female occupations, and argues that because the whole notion of profession is gendered, female professional projects have been ignored, and only successful projects of class privileged males have been researched[13]. This was especially true of nursing which was consigned to being defined as a semi-profession (Etzioni 1969), a definition which is somewhat deterministic in character, as it implies little opportunity for nursing to develop professionally. The occupations so described have a limited knowledge base, and so the extent to which professionalisation is achievable is limited. Parkin (1979), however, states that the case for a discrete knowledge base as pre-requisite for professional status is taken for granted rather than argued, as is the assertion that women more readily accept the bureaucratic controls which depict these occupations. He gives as a more plausible explanation for the sex composition of lower

profession the argument that men, for whatever reason, have not prized these occupations, and have therefore not entered them in large numbers. If they had then these occupations would be more likely to obtain full professional status. Witz finds this argument curious, confining gender to a contingent rather than a determining factor in social closure. She, on the other hand, argues that gender influences both the form and outcome of professional projects.

Medicine is a profession, and nursing, being subordinate to medicine, is doubly disadvantaged in that it can never achieve professional status and is, moreover, characterised by its relation to it. That medicine was predominantly male, and nursing predominantly female was used to underpin the whole concept, yet without an open acknowledgement of the gendered notion of profession. As Witz (1992:60-61) argues:

> The semi-profession thesis is based on an androcentric model of profession, which takes what are in fact the professional projects of man at a particular point in history to be the paradigm of profession.

The use of the phrase 'gendered notion of profession' leads to some equivocation regarding Witz's argument. It can be taken to mean that professions are inherently gendered, and as such represent a unique type of occupation. An alternative reading is to view gendering is an important exclusionary and demarcatory strategy, but one that is not unique to professions. It is this second interpretation that I wish to pursue.

When discussing the strategy of excluding unqualified practitioners as part of the professional project, Larson does not consider the consequences in terms of the exclusion of women. Women were systematically excluded, for example

from medical schools and universities, thereby denying them opportunities to acquire the abstract body of knowledge necessary for inclusion. This Witz views as the major factor in the closure against women. They were also over-represented in the groups of healers who were not admitted to the unified medical profession after the 1858 Medical (Registration) Act. As Versluysen (1980:186) comments:

> If sex were not the main criterion of professional membership, it would be necessary to explain why certain categories of relatively uneducated men were included in the profession [of medicine], whilst more highly educated upper-class women were not.

Female healers had failed to gain a monopoly over their practice, or control over an area of work which could compete against a unified medical profession.

Davies (1996:669) states that profession "celebrates and sustains a masculinist vision." Others, too, have commented on the way ideas about gender roles and images have been used to explain the supposedly 'natural' division of labour, reflected in the professional work of men and the supportive role of women. For example, as stated in chapter 1, Gamarnikov (1978) has likened the doctor/ nurse relationship to the husband and wife of the Victorian household. The authority delegated to the wife (nurse) to organise domestic arrangements and control servants did not undermined the authority of the male head (doctor). Moore (1988) also uses the analogy of the Victorian household, and argues that the medical profession saw female nurses as a threat to patriarchal values. The ideal type of professional as wholly autonomous, possessing expert knowledge which is utilised with a concerned detachment, can only be

preserved by the preparatory or subsequent actions of others, usually women. This serves to reinforce the gendered conceptualisation of profession, while the work of others tends to remain unacknowledged and underconceptualised. This social organisation of work:

> valorise[s] the masculine ..... repress[es], eclips[es] and demean[s] those qualities which are culturally assigned to the feminine, thus trivialising, or at least failing to acknowledge the work that women do in support of the professional ideal. (Davies 1996:672)

An example of this is the fleeting encounter between consultant and patient during the hospital ward round. This can only be sustained, argues Davies, by detailed preparatory and follow up work carried out by others, usually female clerical staff and nurses.

Relevant issues of professionalisation and social closure are, therefore more complex than concepts of inclusion and exclusion, as they are utilised by closure theorists, because women *are* included, but in a particular way. Inclusion of "the Other" (Davies 1996:672) is required but denied. Davies describes two effects of this, the first of which has relevance to district nursing. When women attempt changes in the world of paid work, they are trying to gain inclusion into a system of relations, which already relies on their inclusion in order to function, but where that inclusion remains hidden. This demonstrates the contradictory nature of the struggle women are engaged in. Davies does, however, question the extent to which closure theory can accommodate gendering in the discursive sense that she uses it.

Crompton (1987) argues that although credentials are becoming more important in the allocation of occupational positions, a male culture tends to

dominate in organisations, with women being accommodated in top managerial or professional positions only because of their 'exceptualness'. Although the possession of credentials may mean that men and women are treated equally in terms of conditions of service, gender will play a significant role in their treatment within the organisation that employs them.

Witz (1992:64) argues for "a less androcentric terrain within which to locate discussions of professions and patriarchy." She utilises Larson's professional project, as it is consistent with Freidson's (1994:25) assertion that "there is no single or truly explanatory trait or characteristic - including such a recent candidate as 'power' - that can join together all occupations called professions beyond the actual fact of coming to be called professions." Her use of empirical case studies allows analysis of claims for professional status by individual occupations, rather than comparison to some general, fixed concept. This conflicts with Abbott's position, which argues against a case study approach, but Witz concludes that the gendered notion of profession can only be addressed by considering the diverse and individual ways by which female professional projects dealt with patriarchal institutions. For example, how could women utilise credentialist tactics when universities were the exclusive preserve of men, who used their power on governing bodies to exclude women. Witz utilises Parkin's concept of occupational closure to analyse female professional projects.

This, however, ignores gender and so:

> a conceptual model of the specifically gendered dimensions of occupational closure will therefore be concerned with how occupational closure

> strategies provide the means of mobilising male power in order to stake claims to resources and opportunities distributed via the mechanism of the labour market. (Witz 1992:44)

Witz (1988) also notes the importance of not confusing process and outcome.

Gender segregation of jobs is the outcome of the ongoing process of gendered occupational closure in the labour market. The position that district nurses attained is partly the result of this process, which will be a recurring theme of this thesis.

Jurisdiction

Closure theory is concerned with established occupations attempting to gain or maintain a position in the labour market, but does not attempt to explain the genesis of those occupations. Abbott (1988) argues that the current concept of professionalisation focuses on structures rather than work, and that a more useful concept in considering the emergence of occupations is jurisdiction. He defines the concept of jurisdiction as "the link between a profession and its work". To analyse professional development is:

> to analyse how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual profession itself. (Abbott 1988:20)

Some commentators (Abbott 1988:387) have argued that what Abbott has given is a general theory of the division of labour, but he feels the focus on abstraction limits his study to experts. I intend to use the ideas contained in his

work to explore an emerging occupation, *ergo* as a theory of the division of labour.

Abbott argues that the study of occupational forms can show how certain occupations control their knowledge and its application, but it cannot tell you why those forms emerge and why they succeed or fail. Only the study of competition can answer these questions. Rather than focusing on organisational development, and individual professions, occupations need to be viewed systematically, with an emphasis on the interrelationship between them. Abbott's thesis includes the genesis of occupations, which he accepts as important for explaining how and why an occupation evolved in the way that it did. This is important for exploring an emerging occupation like domiciliary nursing, which formalised tasks previously carried out informally. Questions are raised concerning how and why this work was given over to others, an aspect not addressed in work such as Larson's, which concentrates on the professional project without considering the relationship with clients or other occupations. In other words the social consequences of professionalisation were ignored.

Jurisdiction is the main concept of Abbott's work, and he describes it as the most important of the exclusive properties of professions:

> Each profession is bound to a set of tasks by ties of jurisdiction, the strengths and weaknesses of these ties being established in the process of actual professional work. Since none of this work is absolute or permanent, the professions make up an interacting system, an ecology. Professions compete within this system, and a profession's success reflects as much the situations of its competitors and the system's structure as it does the profession's own efforts. (Abbott 1988:33)

From this statement it can be argued that Abbott's use of jurisdiction equates to Hughes' concept of 'licence' (legal jurisdiction) and 'mandate' (public jurisdiction).

Jurisdiction is not fixed or static, as external forces will create, abolish or reshape tasks, with a consequent jostling and readjustment within the system of professions as experts seize new problems and shed old ones. The way in which the profession currently holding jurisdiction constructs these tasks is subjective. A claim to full jurisdiction can be made by the settlement of a jurisdictional dispute, but this is not the only outcome. Other settlements can act as a transition, for full jurisdiction is usually the goal. A jurisdictional dispute is usually made firstly in the public arena and only later in the legal arena, and is based on the power of the profession's abstract knowledge to define and solve certain problems, which may or not be under the full jurisdiction of another professional group. Where jurisdiction is held by another group, the challenger will exploit the weakest aspect of the incumbent's structure, be it efficacy or disciplinary power. In arguing for a trained district nursing service the lack of training and perceived moral failings of handywomen and others were cited by Florence Lees. This tactic was not exclusive to district nursing, however, as nursing reformers generally were vilifying what were classed as old style or traditional nurses in an attempt to replace them.

The challenger will nearly always be a formally organised group, but Kronus (1976) argues that, historically, although the actions of professional associations were necessary they were not sufficient. Organised pressure was only successful when market conditions favoured the occupation, and it was able to demonstrate that it controlled a sizeable portion of the market.

Freidson (1996) distinguishes between the establishment of professionalism, when a professional association was not always necessary, and the reforming of established professionalism, when it is convenient for the state to have an organised association to represent practitioners and legitimate state policies. He also makes the point that a professional association is not synonymous with a profession, and in 1994 argued, as did Halliday (1987), that the relationship of the collective membership to the formal leadership is always problematic.

There are, at any one time, a finite number of jurisdictions, so a variety of alternatives are achieved by limited settlements. Abbott cites nursing as the classic case. Florence Nightingale envisaged an occupation separate from medicine, stating that "the Matron should be responsible to the governor of the infirmary alone for the efficient discharge of her duties; and the Nurses should be responsible to the Matron alone for the discharge of their duties".[14]

Resistance by the medical profession, however, led to nursing being subordinated. Subordinate jurisdiction is generally a public and legal settlement, and in the past often resulted from an unsuccessful attempt to subdivide a full jurisdiction. As the division of labour becomes more complex, subordinate groups are often created without contest, which has great advantage for dominant groups. Medicine successfully argued that care and administration were subordinate to medicine, thereby controlling nursing, and as newer occupations emerged, such as radiography or physiotherapy, they were incorporated into this power structure.

Abbott does not discuss the possibility of occupations endeavouring to circumvent subordination[15], but a feature of early district nursing associations

was the development of a strand of nursing outside the control of medicine. Why this did not continue will be addressed in subsequent chapters.

Abbott discusses two ways in which new groups enter the workforce: Firstly, by a clientele settlement, where a powerful profession ignores a potential clientele and para-professionals appear to provide a service to a forgotten group. In Abbott's thesis these para-professionals later attack the dominant group for jurisdiction, but I would argue that this is not inevitable. It raises questions about why a profession would ignore a potential client group. Presumably the group will not benefit the profession, perhaps because it is unlikely to pay fees, is not important within society, or association with it will lower the status of the profession. In the nineteenth century the poor were treated in voluntary hospitals for certain categories of disease, and for the first time power relations between doctor and patient were such that doctors were able to use the mass of sick poor for examination and experimentation (Waddington 1973). There was no impetus for doctors to treat the poor in their own homes, as they could not be selected in the same way that admission to voluntary hospitals could be controlled. Doctors who held a voluntary hospital honorarium came into contact with wealthy patrons of the hospital, who were potentially status enhancing patients. There was no such incentive to visit the sick poor at home. Hence they constituted an ignored clientele, which was available to other occupational groups.

Abbott's second way for new occupations to enter the workforce is by enclosure, when a group claims jurisdiction over a task previously common to a number of professions. Nursing is an example of an occupational group coming

into existence by combining the caring and domestic functions of hospital work, previously separate occupations.

Of relevance here is the concept of fusion (Dingwall 1983), which describes the way in which diverse local methods of work organisation are brought together under a single device, with a consequent homogeneity in the restriction of actions carried out under the name. An attempt was made in 1887 to bring together the various district nursing services under the umbrella of the Queen's Institute.[16] Different local societies had grown up in response to various initiatives, and what work was carried out was defined according to the vagaries of the initiators - for example, some included monthly nursing among their duties, some had separate nurses for infectious cases. There were also differences over the length of training thought appropriate for nurses, and the location of that training. Fusion, however, in attempting to bring together disparate elements into a single entity is, as Dingwall has demonstrated with health visiting, a long process. In the case of district nursing it did not succeed until after the creation of the National Health Service.

When viewing these changes, Abbott argues that they must be examined not in their effect on individual professions, but in their effect on the structures that make up the systems of professions. This accords with his stance that too many authors have studied single professions, and ignored the system.

The idea of a 'system' of professions is criticised by Macdonald (1996) who argues that professions may not impinge on each other in a systematic way, and that they also interact with non-professionals, with clients and with the state. This may, however, reflect a misinterpretation of Abbott's use of the word 'system', which was used in an ecological, rather than a Parsonian, sense.

Turner (1989), in an otherwise complimentary review, states that Abbott does not raise the fundamental question regarding the function of professional culture in a capitalist system.

Knowledge base

Abbott stresses jurisdiction over task as defining an occupation, rather than its knowledge base, although it will sustain this by the power and prestige of its academic knowledge. He denies, however, that abstract professional knowledge is continuous with practical professional knowledge, and argues that it is, rather, largely symbolic. Larson, on the other hand, in recent work (Larson 1990), professes a general theory of professions of the type she formulated in the 1970s to be less productive than a move beyond this towards questions of the construction and social consequences of expert knowledge.

This begs the question of how useful the question of 'expert knowledge' is in the understanding of early developments in domiciliary nursing. Rueschemeyer (1983:52) stresses the importance of social change and states that "knowledge .... plays a much more limited role in shaping the social forms of expert service than so far assumed." Some authors (e.g. Rafferty 1995, Versluysen 1980) have claimed that medicine gained status because of its practitioners' social position and gender, before it could demonstrate therapeutic superiority over the competing treatments of other forms of healers. Similarly, Ramsey (cited by Larson, 1990) argues that the protection of a strong state can grant an occupation social power before it has demonstrated technical superiority. Others (Peterson 1978, Loudon 1992) point to increasing scientific knowledge

being the basis for the development of successful medical treatments during the nineteenth century.[17]

In the case of district nursing, it has already been stated that this was the formalisation of tasks previously carried out informally, and that any differences were likely to be qualitative. The knowledge base was shared by those carrying out the tasks formally and informally. Towards the end of the nineteenth century, claim to a superior knowledge base was one of the strategies used by professionalising district nurses in order to differentiate between themselves and the less educated or amateur.

Freidson (1994) differentiates between knowledge, and the exclusive use of that knowledge. It is the latter that confers power onto its possessors. Nursing has always been problematic in its use of knowledge, in that it is eclectic, without a discrete body of exclusive knowledge, although some nursing theorists do try to claim one (e.g. Fawcett 1995). In creating, disseminating and, to a lesser extent, applying knowledge nursing is derivative, relying to a greater or lesser degree on other academic disciplines.

Parkin (1979) argues that this lack of a sufficiently developed knowledge base will always preclude complete social closure, despite the possession of formally acquired qualifications. Monopoly over a body of knowledge has helped to create a status for members of professions, above that of other occupations.

Freidson (1996) states that the relatively high standing of professions in classifications of the labour force is mainly due to the kind of knowledge and skill thought to be required for their work. For personal social services such as nursing, without a body of knowledge, authority is claimed on a more comprehensive experience than any single lay person seeking help for a

particular problem could have accumulated (Freidson 1994). Even as the consumer becomes more knowledgeable, the professional is always acquiring new knowledge at as least as fast a rate, perpetuating the knowledge gap. District nursing, as the formalisation of tasks previously carried out informally into an occupation, needed to differentiate between the knowledge and experience of the nurse and anyone else, for instance a member of the household carrying out the same work, in order to justify its position as a paid occupation. This was based on the quality of the work carried out and a knowledge of sanitary law, with some practitioners also claiming a social class superiority in their influence on patients and their families. The role of these issues as factors in the professionalising strategies of district nursing will be addressed in chapter 8.

Most writers, then, accept the importance of a knowledge base for professionalisation, but Abbott is alone in perceiving jurisdiction over tasks as of primary importance. This may be because his theory encompasses genesis of occupations, when a knowledge base would not be well developed. In the early stages of an occupation, what its members do will be more defining than what they know.

Education and training

The importance of education and the acquisition of credentials attesting to competence are frequently cited in sociological work on professions as important professionalising strategies.

For Larson (1977) the rise of modern professions is crucially linked to the use of the competitive examination system, and coincides with the rise of industrial

capitalism. Weber (1948) views the development of diplomas and certificates as creating a privileged stratum, which makes claim to monopolise socially and economically advantageous positions. This rise is also connected to the 1832 Electoral Reform Act, but although democratisation should not be overstated:

> The constitution of modern professions and the emergence of a pattern of professional career represented for the middle classes a novel possibility of *gaining status through work.* (Larson 1977:5, original emphasis)

Under capitalism there were no legal or formal sanctions against social mobility, whereas in pre-capitalist systems there were (Parry & Parry 1976), which provided an incentive for professional education. The way this was achieved was, however, historically and culturally specific. In France and Germany the state created universities for the training of professionals, whereas in England universities at first opposed professional training within their portals. Here professions conducted their own training, with university education frequently entering the picture much later, after professional associations had been formed and specialist journals founded (Abbott 1988). Freidson (1996) claims that shelter, or closure, is maintained by enforcement of the requirement that only those with occupationally generated credentials testifying to their competence can be employed to perform a defined set of tasks. This emphasises the importance of vocational training for professionalism. Professional training, unlike training for crafts, takes place outside the labour market, in classrooms. It can also take place within the practice setting, but outside of the ordinary workplace. "In both cases, only members of the occupation serve as teachers, but in the craft method, teaching

is a complementary activity for selected workers, while in the professional model teaching is a full time activity." (Freidson 1996:9). Hughes (1971) adds that having a Bachelor's or Master's degree as an entry to a profession also adds to its status. This in turn allows it to be able to increase prerequisites for entry to the initial course, and to raise the cost, compounding the social class dimension.

Nurse education, which began in the nineteenth century, and continued in the same vein until recently, has not conformed to either the craft or the professional model, but is rather a hybrid. Training took place both in the classroom and in the workplace, and it was given not only by members of the occupation of nursing, but also by members of other occupations, notably medicine. This has helped to make nursing's claim to professional status more problematic, as the emphasis of training was to provide nurses with a rationalist ethos and the values of scientific medicine, in order to facilitate compliance with medical instructions (Rafferty 1995).

For Freidson the existence of university based education for professions has advantages regarding the claims that they can make for themselves. It can be claimed that all students are exposed to the same body of knowledge and skill. Further, that body of knowledge can be created and expanded by research and scholarship, and new forms of knowledge can be developed. Freidson (1994:143) calls these researchers and scholars "a special class of members", who can assist the profession by supplying advice on areas such as policy, or sitting on expert committees. This can, however, lead to tension between academic and practising members of a profession.

In the nineteenth century, emerging professions began to distance themselves from aspects of their occupation that were associated with 'trade', for example apothecaries from chemists (Kronus 1976), surgeons from barbers. In doing this they were also distancing themselves from the craft aspects. The key to this was the claim of competence as measured by a system of testing, and later by professional schools, so the potential for market control depended on an educational system which moved away from the study of classics to one utilising a body of abstract knowledge. As argued above, for the middle classes education was easier to obtain than capital, thereby providing a route to individual mobility.

Hughes (1971) states that professional education is not merely the learning of skills, but an initiation into a role. Students learn, although they are not overtly taught, to internalise certain values and attitudes, and the image of that profession which it has created for itself, becoming part of the culture. It is argued in chapter 7 that hospitals were originally used for district nurse training in order to teach obedience and deference to autonomous nurses, rather than the skills required to carry out the job. Later, a more scientific training was developed in order to reconstruct nursing as a professional occupation, and this is discussed in chapter 8.

Hughes (1971) identifies certain problems with professional education, such as trying to predict what the work of the profession is going to be in the future, and educate students for it. This is compounded by the fact that professionalising occupations discard what they see as low status, menial tasks. When do educators acknowledge that certain tasks no longer constitute part of a profession's role, and cease to teach them?

Conclusion

My major concern with both functionalist and neo-Weberian writers is that they do not allow for the genesis of occupations. As stated earlier they take for granted the concept of 'occupation' and use this as a starting point. This is too far along the evolutionary scale of professionalisation to be useful in exploring an occupation like domiciliary nursing, which was emerging and developing during the course of the nineteenth century. For example, Larson's assertion that occupations which transacted their services on markets had to create as well as protect those markets, raises questions about those occupations. To adopt the language of classical economics, why did the supply side emerge as an occupation, and why did the demand side respond. Conversely, why did the demand side emerge, and why did the supply side respond? In either case, the means for the occupation to develop was created, but remained unacknowledged. This limits the usefulness of Larson in analysing the emergence of district nursing, until it had become established and attempts were being made in some quarters to make it a suitable occupation for middle class women.

Ideas of what constitutes work, and when that work becomes an occupation are far more relevant to emerging occupations. Questions such as why did an occupation emerge when it did, what were the processes involved in its development, and for some occupations, why did it change from being an informal to a paid occupation? can be answered more satisfactorily using these concepts. Jurisdiction allows for the genesis of occupations, and an examination of the process of development, exploring the link between an occupation and its work.

Occupational closure does, however, provide a theoretical framework for understanding why and how district nurses became subservient to the medical profession, and later developments in domiciliary nursing, such as the formation in 1887 of the Queen's Institute, with its insistence on high entry criteria. Could this be interpreted as a professional project, hampered by the diversity of the occupation and lack of collectivity? This question will form a major focus of chapter 8.

Most writers[18] discuss professionalisation as a strategy adopted by the members, but the impetus for home nurses to professionalise (in terms of developing an examination based occupation for educated women) came in the first instance from outside the occupation, namely from elite committees which decided what characteristics were required to lift the status of district nursing, and recruited women who fitted the image they had created. Hughes (1971:293) is almost alone in acknowledging that:

> occupations vary greatly in the degree to which they become the master determinants of the social identity, self conception and social status of the people in them .... occupations vary greatly in their autonomy in determining what activities are their duties and prerogatives.

Occupations of long standing would resist attempts at outside control of their work more than those more recently established. Freidson (1996) acknowledges that control of work may be by consumers or management, but aligns professionalism with occupational control of work. As will become apparent in subsequent chapters, the emerging occupation of district nursing was susceptible to control from various quarters - mainly male, a factor which affected its opportunity for professionalism.

Rueschemeyer (1983:47), however, argues that historically and comparatively professional self control is not the only method of control of expert services. "To conceive of it as the only, or even the predominant, institutional form of expert services is an act of cultural and historical parochialism."

It has been argued that the impetus for the genesis of domiciliary nursing was social rather than technical change. As stated above, Rueschemeyer (1983) also stresses the importance of social change, which raises questions of what social changes were involved, and why they featured when they did. Abbott (1988:91) calls these "external forces", which create market conditions, and can disturb the system by opening new task areas for jurisdiction, and destroying old ones.

As domiciliary nursing was heterogeneous, not all societies were influenced by the same social factors.

I suggest here possible relevant factors, which may be divided into two groups and which have at their roots the transition to modernity:

1. Factors concerning the clientele
2. Factors concerning the workforce

Factors concerning the clientele were more influential over those charities whose desire to control the lives of the poor was more important than the status of nursing:

- Spatial distancing of rich and poor with the consequential reduction in the influence and control of the former over the latter.
- Distancing within the workplace with the growth of supervisory and managerial staff between owners and labourers.

- Direct social policing was more difficult in the growing cities.
- Growth of philanthropy, especially among evangelicals.
- Fear of revolutionary activity in Europe spreading to England.
- Genuine desire to improve conditions for the poor.
- Rise in societal dominance of Victorian middle class family values.

Factors concerning the workforce influenced those whose main concern was to develop nursing as an occupation:

- The 'problem' of surplus women.
- The lack of suitable jobs for middle class women.
- The rejection of the domestic role by many women, and the emergence of feminism.
- The desire to raise the status of nursing.
- The existence of an elite group with the power to set the agenda.

The two groups are not mutually exclusive, and cutting across all the above reasons are issues of social class and gender. All of these factors will be explored in subsequent chapters.

Of use, here, in linking structure and agency, is Hughes' (1971:287) discussion on exchange, which, he argues, is present where there is differentiation of function. The division of labour involves many kinds of exchange, not just economic, several of which may be going on simultaneously. In many occupations, exchanges occur on at least two levels:

- exchange between a person and others with whom s/he interacts in the occupational role - e.g. clients, colleagues.
- exchange between the occupation and the society in which it occurs, which underlies license and mandate.

This may help to explain professions acting simultaneously in an altruistic manner, and in their own self interest. Self interest may be compatible with the public interest, or the two may coincide at certain points in time, and over certain issues. Different levels of exchange are occurring at the same time. Individual district nursing societies had different agendas, therefore the extent to which they are representative of either of the above models, or reflect them in their structure is diverse. In this home nursing can be likened to the later development of health visiting which Dingwall (1983:615) described as being in 1904 "a patchwork of local responses to commonly experienced social problems."

Social change needs also to be viewed in terms of its indirect effects. Abbott considers changes like the rise of large scale organisations and technology, which led to the creation of some occupations and the decline of others, purely by what takes place in the public sphere. He does not consider the effect of industrialisation on patterns of living, on the social meaning of 'home', and the consequent effect on occupations. He alludes to it in discussing the creation of the problem of adjustment, leading to the creation of professionals to deal with it, for example psychiatry or social work, but this is not the same as considering the consequences within the private domain, for those whose roles have moved into the public sphere. Is a vacuum, or vacant jurisdiction, created when a role

is vacated in the private sphere by someone who used to fill it going into a new role in the emerging large scale organisations?

No existing theory of occupation and profession would appear to adequately explain the genesis and subsequent development of domiciliary nursing. Using 'work' and 'occupation' as starting points, the concepts of jurisdiction and occupational closure are all useful in offering some explanation for different stages of occupational evolution. These, then, will provide the theoretical framework for formulating the questions which arise from the literature review, and to sociologically analyse the empirical data obtained from nineteenth century primary and secondary sources.

Notes

[1] BL add. ms. 47756

[2] The Bodleian Library 15192 e 8 Broadwood B (1887) 'Nurses for sick country folk':12

[3] An exception to this was asylum nursing which, because of its roots and its association with custody and restraint, was seen as more naturally men's work.

[4] The opposite is also true, as Freidson argues that tasks which were once performed by paid labour can revert to workers in the informal and/or the subjective labour force.

[5] Freidson raises the question of motivation for volunteer work. In the case of lady superintendents this is bound up with opportunities for middle and upper class women outside the home, and will be explored in chapter 5.

[6] Freidson (1994) argues that the seeming unanimity about professions, in fact hides contradiction and confusion over profession and the related concepts of professionalism and professionalisation. It relies on common usage of the same word, rather than agreement on its meaning. Here I will use Freidson's (1996:3) definition of professionalism as "occupational control of work".

Similarly 'professionalisation' is a twentieth century analytical term used here to describe historical processes. It must be accepted that there is a difference between the sociologist's use of the term and that of the actors involved at the time. Yet, as Freidson (1994) points out, what other words do we have to describe the processes that were occurring? This will become an issue in chapter 8 where I discuss the moves to create a profession which would attract educated ladies, and I will endeavour to avoid a present-centred approach to analysis.

[7] See, for example Rueschemeyer (1983), Larson (1977).

[8] As well as the concept of fission, Dingwall identifies occupational formation by fusion, and this will be discussed later in this chapter.

[9] LMA H1/ST/NC7/3 Nightingale (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':10

[10] Although Weber regards the ownership of property as an exclusionary form of closure (see Weber 1948, for example), for the purposes of examining district nursing only occupational closure will be considered.

[11] As most surviving documents are official records of associations, it is difficult to say whether this disregard for monetary reward was shared by the nurses themselves.

[12] See, for example Murphy (1984).

[13] An exception are Parry and Parry (1976:162) who do acknowledge that "sexual divisions in society must be treated as a structural factor which is of equal importance with social class."

[14] LMA H1/ST/NC7/3 Nighingale (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':9

[15] He also does not consider the possibility of another occupational group (e.g. managers) becoming more controlling than the dominant profession.

[16] This forms a major focus of chapter 8.

[17] Judging the efficacy of medical practice *vis a vis* that of other practitioners is difficult. Firstly there is the problem described in chapter 2 of the partial nature of what has survived, which favours those whose perspectives tend to be written rather than spoken. Also, much

work on the progress of nineteenth century medicine is concerned with professional organisation as opposed to therapeutic efficacy, and Peterson has argued that efficacy was not the criteria by which Victorian medical men were judged. On the other hand, Rafferty tends to glorify untrained nurses, and ascribes to them a level of skill that she does not demonstrate empirically. Their vilification at the hands of medical men and others is, however, well documented and it may be that an account biased towards the perspective of nurses' detractors does not allow for objective assessment.

[18] For example, Freidson (1994), Hughes (1971).

CHAPTER 4

Health and population in nineteenth century England

Introduction

The last chapter argued that social, rather than technological, change was the impetus for the emergence of district nursing as a formal occupation. It created the market conditions which opened up a new area of work, in both the formal and subjective economies, over which an attempt to claim jurisdiction could be made.

The occupation of district nursing, therefore, needs to be understood within the framework of macro and micro social structures. This chapter will explore the macro-sociological issues of class and space in an industrial and increasingly urban society, and the effect of these on health. Chapter 5 will consider the micro-sociological concept of home, and the changing role of women within it.

Space and class

The nineteenth century was characterised by rapid population growth. At the time of the first census (1801) the total population of England and Wales was 8,892,526. One hundred years later it had reached 32,527,843. The population doubled over the first half of the century, and almost doubled again during the second half (Bédarida 1990). This increase was concentrated in urban areas, which saw their populations rise from 33.8% of the total in 1801 to 78% in 1901, whereas rural districts experienced depopulation, particularly during the

second half of the century (Law 1967).[1] The pre-industrial link between population size and food production, whereby periodic harvest failure and famine helped to counteract the rising birth rate, had been eliminated (Carter and Lewis 1990). There was a rise in real wages over the century and a fall in mortality rates, but fertility rates remained high until the latter part of the century, crude birth rates beginning to fall around 1880 (Hunt 1981)[2]. A lesser factor contributing to the population increase was immigration, the largest single group being from Ireland, although this has to be balanced by Britons emigrating. In the middle of the century emigration accounted for one third of the excess births over deaths (Bédarida 1990).

In 1851 for the first time over half the population of England were urban dwellers (Bédarida 1990),[3] but the change from a rural to an urban nation was not merely numerical. It brought about a new system of social relations and new lifestyles. As much of the migration into the cities was by young adults (the largest single group being 15-30 year olds), they helped to boost the rate of natural increase as well as adding to the population by their presence. They were more likely to marry, and married younger, than their rural counterparts, but their rates of fertility were no higher than those of the rural population (Dennis 1984). During the early part of the century migration accounted for most of the increase in the population of London, but by the middle of the century, despite the problems of sanitation and overcrowding, it was the natural increase of births over deaths (Carter and Lewis 1990). This pattern was reproduced in other large urban areas.

Social geographers tend to view the growth of cities using a Weberian analysis of class conflict, but using a historical materialist approach, Harvey (1973)

argues that a new form of urbanism was necessary for the transformation from mercantilism, monopolistic and regulated by guilds, to the competition and self regulation of industrial capitalism. Grint (1991) concurs, adding that guild organisation in towns inhibited levels of production, through members' influence over labour and product markets, whereas in rural areas wages were cheaper and restrictive practices fewer. Because of this the industrial revolution was characterised by the creation of new cities, such as Birmingham and Leeds, rather than the adaptation of old ones. Here the forces of production could be reorganised to take advantage of mechanisation, technology and economies of scale. Stratification based on class rather than rank was the significant feature. Cities did not expand in a uniform manner and there was much diversity in their form and social relationships. Abrams (1978) warns against the tendency of urban historians and sociologists to reify the city, and to treat all cities as homogeneous. Harvey (1973) argues that urbanism reflects a hierarchical ordering of activity, which is consistent with the dominant mode of production, but that within this it can exhibit a variety of forms.

In 1851 nearly 2.5 million people lived in London, and its geography, like that of most expanding British cities developed in a way that segregated rich and poor.[4] Bethnal Green, for example, had at one time been an upper class neighbourhood, but by the 1860s the rich had moved to the west of London, away from the smoke, and what had once been the coach house of a large mansion had been converted into a factory (Davies 1977). This was facilitated by the separation of the middle class residence from the workplace (Summers 1979). "Towns expanded through infill and suburban development with little co-ordination or planning with consequent effects on health, congestion and an

array of what have come to be known as 'social problems'" (Williams 1990:172). Working class areas were equated with darkest Africa, and the fear of unknown, irreligious inhabitants was one impetus to maintain and increase segregation (Cannadine 1993). Dennis (1984) argues that class segregation was not new in the nineteenth century, only its perception as a major cause of immorality and irreligious behaviour.

The Great Exhibition of 1851 ushered an age of prosperity which lasted until 1873 (Gregg 1973). There then began a period of depression which lasted until 1896. Economic historians are not agreed about whether the so called 'Great Depression' was in fact as long and as persistent as often assumed. Royle (1987:138) talks about "intermittent depression", and Feinstein (1992) argues that, as there were three measures of gross domestic product (GDP), interpretation is difficult. He does, however, point to falling arable prices and a decline in manufacturing profits as evidence that Britain's position of economic supremacy was weakening in the face of international competition. Yet for many workers a drop in wages was offset by a sustained fall in the price of food (Pugh 1994).

The annual reports of some district nursing associations mention depression, both in rural and urban areas, so it may well have been generally perceived as such. The Stratford Association, for example, in 1879 commented on the amount of destitution and sickness existing in Stratford because of the recent depression in trade and agriculture, and the Institute of Trained Nurses for the Town and County of Leicester stated that, due to the depression of trade and consequent poverty, 1878 was the most expensive year they had experienced in their most deprived district.

For a few there was great wealth, and in 1870 *per capita* income was the highest in the world (Bédarida 1991), but this was not shared by all; during the 1860s in London, for example, real wages did not rise, and in some years actually fell. Rural poverty increased as surplus population suppressed wage rates of farm labourers (Newby 1987). There were also localised variations in prosperity, for example the cotton famine in Lancashire during the American Civil War. For the middle classes, however, incomes doubled between 1851 and 1871.

From the end of the eighteenth century the middle classes had been growing numerically and proportionately[5], and in terms of wealth and importance. The term 'middle class' is used here as if it were a homogeneous group. As Davidoff and Hall (1983) have pointed out, however, the middle ranks of society were racked by divisions - Anglican and non -conformist, Tory and Whig, professionals, manufacturers, farmers etc. Williams (1987) has also commented on the complexity of the middle class and its fragmentation into sub-classes. For the purposes of this thesis Royle's definition of nineteenth century 'middle class' will be utilised to clarify what is a rather amorphous term:

> Some were tenant farmers with interests different from those both of their landlords and labourers; others were intermediaries between producers and consumers, in either commerce or industry; and yet others provided services in the professions or public administration. At the lower end they almost merged with the working class .... At the upper end they aspired to, and increasingly achieved, acceptance into the aristocracy. (Royle 1987:101-2)

The middle class move out to the suburbs, leaving inner city areas to the labouring classes and the poor, [6] was in stark contrast to the structure of medieval cities, where rank society (Harvey 1973) dictated that the rich lived within the city walls near to their businesses and in relative safety. The poor had to survive as best they could outside.

"Suburbs distanced the threat of social change and offered a spatial device which inoculated the middle class against the hazard of the city without requiring them to relinquish their political control over it." (Morris 1993:24). They provided a safe haven, against the perceived threat of large assemblies, with their potential for riot and disorder, thought to be associated with Chartism and trade unions. There was also a more pragmatic reason for the distancing of home and work. Industrial processes made most businesses undesirable as residences, so that professional people like doctors maintained the link between home and workplace later than industrialists (Davidoff and Hall 1987).

Artisans' housing came between that of the labouring classes and the middle class, and provided a buffer.

Suburbs were also a sign of increasing wealth, as the move away from the production unit could only be achieved when women were no longer needed in the running of the business, although, as Davidoff and Hall (1987:117) point out, not all women were prepared to give up their involvement. Among evangelicals at least, women's role in business was "a matter of negotiation, rather than a fixed code." Leisured women could then create a lifestyle of gentility, copied partly from the upper class and based around leisure, for husband and family. The separation of home and work also meant a

demarcation between work and leisure time, although the complexities of demarcating each has been addressed in the last chapter, and will be raised again in chapter 7.

Hall (1993) charts the move in 1844 of the Cadbury family from their home above the tea and coffee shop, which was owned by John Cadbury, to a house in Edgbaston, which at the time was in the country. Unlike her mother in law who played a large part in the running of her husband Richard Tapper Cadbury's drapery business, John's wife Candia was never actively involved in the running of his shop. The move out of the family shop severed all links between the Cadbury women and business.

For the middle classes the move out of cities was choice; for the working classes[7] the move into them was necessity. This was not a uniform move, as industrialisation continued in a haphazard manner with a different pace according to the industry and the rate of mechanisation (Gregg 1973). As Bédarida (1990:57) points out "there was a hybrid mixture of archaism and modernism. Side by side with highly mechanised activities there continued to exist many sorts of pre-industrial production."

In the same way that urban areas were heterogeneous, so there was no uniformity about the notion of rural England (Howkins 1991). As stated above, the most obvious feature of nineteenth century rural life was a slowing of population increase up to 1861, and of depopulation after the 1870s, but agriculture still remained the largest single employer until the census of 1901. This crude figure, however, encompasses all from the largest landowner to day labourers, and almost certainly underestimates women's agricultural work.[8] It

also hides the blurred nature of occupational boundaries, as some people took many seasonal jobs over the course of the year (Samuel 1975).

Depopulation was differentially experienced, as migration was often a two (or more) staged affair, with individuals moving to larger villages, and then to towns and cities. Even one family leaving a very small hamlet could, however, have a devastating effect on the local economy (Howkins 1991). It was not just to work in industry that people were leaving the countryside, but also, especially among women, to join the increasing domestic service market. Rural women generally had a reputation for reliability, and many live-in domestic servants were originally from rural counties like Norfolk (Howkins 1991). Landownership meant that many families were dependent on one person or family for both home and work, and were subject to control in their behaviour and habits. Political or religious dissent, drunkenness, or any other 'moral' failing was liable to result in eviction. Highly controlled rural villages were regarded by their owners and many contemporary philanthropists as 'model' villages, but the estates on which they relied for employment and housing could not have survived without the casual labour of neighbouring villagers, whose physical conditions were likely to have been insanitary and overcrowded (Howkins 1991). Pigsties and privies often abutted outside walls of cottages, and farmyards were undrained, making conditions insanitary, especially in winter. Many villages remained dependent for water on brooks and fetid ponds, and in small towns pumps were erected slowly and often as a result of philanthropy, or to be run for profit (Davidoff and Hall 1987). In Warwickshire, the majority of wells were polluted, leading to high infant

mortality from diarrhoeal diseases.[9] Pulling down properties that were beyond repair just added to the housing shortage.[10]

As with cities and their suburbs, social classes were segregated in rural areas. Landowners and tenant farmers tended to live outside villages, and farm workers inside them. This was especially true of Southern England, where more hired labour was employed (Newby 1987).

Despite the reality of rural existence, the idea of a golden age before the industrial revolution when there were no social divisions was widely held, and it was this idealised version which was used as a yardstick by which to measure the degradation of urban society (Davidoff *et al* 1976). It was thought that by translating the characteristics of rural communities to the conditions of urban living social and religious problems could be solved. This was the rationale for district visiting and Rack (1973:358) argues that the idea of districts stemmed from a desire to recreate:

> a semi-mythical harmony of interest and sense of mutual obligation between the different ranks of society, and the social and religious control exercised (so it was said) in rural communities.

From the 1820s district visiting developed rapidly into large scale organisations. Davidoff *et al* (1976:142) argue that historians have overlooked the zealousness with which the Regency and Victorian upper and middle classes attempted "to recreate wherever possible conditions favourable to a stable deference to traditional authority."

The nineteenth century then can be seen, in general terms, as a time when the middle classes were increasingly moving out of the cities and into the suburbs, often trying to create a rural idyll. The cities were growing rapidly

(Birmingham's population grew from 60,000 in 1800 to 260,000 by 1851), as poorer people moved from the country areas in search of work. As house building could not keep pace with the influx, much overcrowding and congestion was created. The social upheaval of rapid industrialisation and urbanisation affected the ability of people to carry out work of use value within the home. As stated in chapter 3, wage labour became much more significant, with work of use value being disregarded. The potential was there for a new or established occupation to fill the vacuum, to carry out for wages what was becoming more difficult to do informally. As will become apparent, no single occupational group initially attempted to claim jurisdiction over caring for the sick in their own homes, and a diverse occupation developed.

The health of the nation

Urbanisation not only affected the ability of people to carry out work of use value, but also brought with it changes in patterns of ill health, and mortality. By utilising available data from the 1911 census, Woods (1985) has calculated differences in urban and rural life expectancy (LE), which are subsumed in overall crude rates. These differences increased over the early part of the century, reaching a peak of twelve years in 1831 when LE was 31 years in large towns, and 43 years in rural areas. After 1861 urban LE increased faster than rural, which led to a general convergence. This 'urban penalty' was ameliorated, according to Mooney (1997) by local initiatives to improve sanitation, rather than general improvements in living standards. The 'rising standard of living' argument was first postulated by McKeown.[11] Szreter (1992), however, concurs with Mooney, stating that McKeown's interpretation

of his own epidemiological data is flawed in a number of respects. He goes on to argue that McKeown's is a Whig interpretation of the history of public health, which concentrates on a few famous individuals and their achievements. By this means he demonstrates that a fall in mortality preceded most public health initiatives.

By looking instead at what was achieved at a local level by public health initiatives and preventive measures, a more adequate explanation for the late Victorian improvements in the health of the nation can be found, which would indicate improved sanitation as the major determinant. These were, as can be deduced from references to water supplies in the last section, somewhat piecemeal, and rising living standards cannot be discounted as a factor. Insanitary conditions led to endemic waterborne diseases, with periodic epidemics - outbreaks of cholera, for example. These affected everyone, even the middle classes with their superior water supplies, and were the impetus for the setting up of some district nursing schemes, many of which were short lived. In Oxford, for example, in the 1832 and 1849 cholera epidemics a greater mortality was noticed among those patients who were institutionalised. During the 1854 epidemic a nursing and surveillance scheme was set up in order to keep victims at home, and to attempt to reduce the spread of the disease.[12] Epidemics were not just a feature of industrialisation, however, as many pre-industrial towns were insanitary places, and, as discussed above, conditions in rural areas were not necessarily better than in urban areas. Before urbanisation there were outbreaks of bubonic plague, for instance, but what characterised the industrial towns was the sheer density of the population, exacerbating sanitary failings and facilitating the spread of disease. The mortality rate in

Liverpool, for example, was c35 per 1000 population in a non-epidemic year, but during epidemic outbreaks of cholera, typhus etc. it could reach 50.[13] Typhus was both endemic and epidemic, and closely associated with overcrowded, insanitary conditions and inadequate nutrition. Unlike cholera it was highly class related, as was consumption, which was the leading cause of death in the nineteenth century.

Crude mortality rates may hide internal variations. Liverpool had between 1861 and 1871 a mortality rate of 38.59[14], one of the highest in the country, yet some districts, like Castle St. and Rodney St., had rates which compared favourably with other cities in the country. Other districts such as Bisham St. and the dock area of Sawney Pope had very high rates. The large proportion of areas of Liverpool with high mortality led to a high crude rate compared with London, where the mean was reduced by the number of 'healthy' districts.

Comparing Rodney St. with Sawney Pope, mortality rates were 10.71 and 55.86 respectively. Four children per 100 died before the age of five years in Rodney St. compared with 26 in Sawney Pope. Even very poor areas of London such as St. Giles did not have mortality rates as high as Sawney Pope.[15]

Fraser (1984) points to the lack of any effective administrative organisation in the early part of the century capable of providing amenities at a rate which could keep pace with the increasing population. Hennock (1998) points out that although compulsory vaccination against smallpox had begun in 1840, an appropriate administration system was not complete until 1874. Early public health legislation was enabling, rather than mandatory, which led to patchy implementation, with local rate payers often opposed to the large capital costs

involved in the provision of proper drainage and clean water. Increasingly, though, during the mid nineteenth century local initiatives led to area specific Acts of Parliament for the installation of waterworks and sewage removal.[16] It was the 1871 Local Government Board Act, and the 1872 Public Health Act which strengthened the public health function of local authorities.

In 1832 Thakrah undertook a very detailed examination of the ill health suffered by workers in various trades and industries.[17] He found that the most healthy people were those of active habits who worked mainly in the open air, like husbandmen. Butchers and drovers also worked outside for much of the time and were well fed, leading to good health. Labourers in these trades, however, had healthy working conditions, but wages too low to feed their families well, and so suffered from gastric conditions and epidemic diseases. Workers exposed to dust generally had very poor health, but there were variations. Sheffield grinders using a wet stone to grind knives usually died at between forty and fifty years of age, whereas fork grinders who used a dry grindstone normally only lived to between twenty eight and thirty two years. Similarly, needle pointers in Worcestershire, who used dry grindstones suffered pulmonary complaints, and tended to die before the age of forty.

Coal miners, who were exposed to dust and inhaled gases were subject to rheumatism, asthma, muscle pains and pulmonary disease. They were also victims of accidents in the mines, and usually died before reaching fifty. Lead miners, especially in sandstone mines rarely reached forty, dying from lung and bowel diseases. Thakrah noted that in one mining village, Arkendale, there were thirty widows under thirty years of age.

In the factories children as young as eight were employed in power loom weaving, but most were over ten. They worked, however, for the same hours as adults, from 6 in the morning until 7 at night. This, Thakrah observed, affected their growth, and he thought that the poor food and little rest would result in many disorders later in life.

Occupations carried out in smaller, less mechanised workplaces than the new factories still had health problems associated with them. Overcrowded conditions, long hours and poor light led to consumption, digestive disorders and sight problems in milliners, dressmakers, and tailors.

The increase in occupational diseases associated with industrialisation encouraged groups of philanthropists to think about ways of ameliorating the problem. Solutions tended to be concerned with treating the effects, rather than the cause, so that the impetus for many emerging district nursing associations was to treat the growing number of industrial diseases and injuries.

Conclusion

A capitalist mode of production brought about changes in living patterns and occupations, which had an effect on health. It was also linked to institutionalisation and the growth of hospitals to care for the sick. Hospitals could not, however, deal with sanitary failings, nor, indeed, with the bulk of ill health, and some commentators perceived the needs of the sick poor as being best met by domiciliary nurses. One effect of industrialisation and urbanisation, then, was to create the conditions in which a new jurisdiction could be identified and eventually claimed. How this occurred will be the focus of later chapters.

Domiciliary visiting also provided the opportunity for the middle classes to observe and influence the lives of the poor in a society segregated by class and space. These issues coincided with the need of some women to find a suitable occupation, whether in the formal or the subjective economy, and the implications of this for the role of women will be a focus of the next chapter.

Notes

[1] Law (1967) states that by the nineteenth century urban settlements were clearly differentiated from rural ones. However, he also points to the limitations of using census data which were not consistent in the use of rural and urban divisions.

[2] Although registration of births was not compulsory until 1837, and even after that there was under-reporting, there is evidence from other sources to suggest that the birth rates of middle class women and the wives of skilled artisans had been falling before this date (Hunt 1981).

[3] See note 1. Howkins (1991) also argues that the census data are misleading, as an administrative definition of 'town' was used, which meant that people from places like Aylesbury or Lewes, which were predominantly rural, were classed as towndwellers.

[4] Segregation in this way would appear to be a rather British phenomenon, because here the increase in population preceded the growth in mass transport, which would have allowed all classes to distance home and work (Cannadine 1993).

[5] By 1851 they constituted c17% of the population (Bédarida 1990).

[6] The exceptions to this were towns constructed mainly for the pleasure of the well off, such as spa towns like Leamington and Cheltenham, where the poor were housed well away from the town centre attractions and public parks.

[7] As with the middle classes, the working class was not a homogeneous group. It included rural as well as urban workers, various levels of skill (and none), and those who were regularly, casually or not employed. The main things they had in common was dependence on the owners of capital, low incomes and insecurity (Bédarida 1990).

[8] The invisibility of women's work from census data has been raised in chapter 3, will be discussed again in chapter 5.

[9] Bodleian 150 g 19(26) Wilson G (1826) 'Sanitary defects in villages and country districts and how to remedy them.'

[10] ibid

[11] See, for example McKeown and Record (1962).

[12] The use of district nurses in epidemics is discussed chapter 7.

[13] BL C.T. 324.(5) Parkes E A, Sanderson J B (1871) 'Report on the sanitary conditions in Liverpool' part ii

[14] The crude mortality rate for London was 24.3; Bradford 26.2; Leeds 28; Hull 24.9

[15] BL C.T. 324.(5) Parkes E A, Sanderson J B (1871) 'Report on the sanitary conditions in Liverpool' part ii

[16] It has to be noted that some of these acts were passed to prevent the imposition of the public health measures of the 1848 Health of Towns Act (Smith 1979).

[17] Bodleian 16171 e 36 Thakrah C T (1832) 'The effect of arts, trades and professions and of civic states and habits of living on health and longevity'

CHAPTER 5

Home, gender and domiciliary nursing

Introduction

Williams (1987:155) argues that home is both a physical and social structure, which reflects and conditions social interactions and social forces, "blending the 'spatial' and the 'social' into an indivisible whole." For some women in the nineteenth century the home was increasingly seen as their natural sphere, with philanthropic pursuits being one of the few outlets for their energies. It was argued in chapter 3 that home also remained the locale of much waged work carried out by women, although this was often not officially recorded. Freidson's (1978) categorisations of subjective and informal labour can be used to define these activities.

As was stated in chapter 1 domiciliary nursing, like all forms of nursing except in asylums, was widely regarded as naturally women's work. As Jameson (1855:83) comments "Everyone admitted as a natural law, an undeniable truth, that early education and the nursing of the sick belong especially to the women." This gender division of labour was used to argue for jurisdiction over this work in both the public and private spheres.

The concept of 'home', women's roles, and philanthropy are therefore strongly linked, both in general terms and in the particular instance of domiciliary nursing. The home was obviously the setting for intervention by domiciliary nursing, and it was mainly women who were involved, either as paid workers,

volunteer supervisors, or fund-raisers. The focus of intervention was also in many cases women, as the recipients of teaching on cleanliness and hygiene. These inter-relationships will be examined in this chapter by exploring the changing notion of 'home', women's roles in society, and philanthropic organisations. To what extent did they determine the specific nature and form of district nursing associations?

The changing notion of home

'Home' assumed a far greater importance for social relations in the Victorian era than in previous times, and the emerging middle classes were the most home and family centred in history (Williams 1987). Changes in the structure of towns and cities, and in the nature of economic activity necessitated reform of household structure and relationships, but this varied in type and intensity. Home became a sanctuary for middle class families. For men it provided an environment away from the hostilities of the world of work, a private place that could not be infiltrated by outsiders.[1] Girls were increasingly brought up to maintain this sanctuary, and educated mainly in domestic matters and the cultivation of skills in art, music, deportment and social etiquette. Their consequent inability in other areas of life was frequently interpreted as incapability. As Jameson (1855:108) commented "It seems rather unjust to sneer at a woman's unfitness for certain high duties, domestic and social, unless the possibility of obtaining better instruction be afforded." Women's 'natural' role, then was socially constructed in a certain way, reinforced and circumscribed by their education, but this role was then undervalued, and not

perceived as important as men's role in the public world of work and civic affairs.

If newly married women had not much idea on running an efficient home there was a wealth of books and journals published in the mid nineteenth century to instruct them, such as Mrs. Beeton's *Household Management* or *The British Mother's Journal*. Correct behaviour and good manners became an increasingly important indicator of status, and it was the responsibility of the wife to ensure conformity. The emergence of what Davidoff and Hall (1983:345) call the "class-gender category" of 'lady' was of great importance in defining the middle class family.[2]

The middle class lifestyle emphasised a well ordered and materially well stocked home, the management of which was the responsibility of the wife, who increasingly shifted the manual work onto servants (Davidoff 1983). Rather than a unit of production, the Victorian middle class home became a unit of consumption and of reproduction[3], not just of children, but also of a set of social relationships and values. This transformation was the responsibility of women, and was bound up with religious revival of the early nineteenth century, and with ideas about temperance. This in turn may have been one response to perceived societal tensions arising from rapid social and economic change (Williams 1987). Jameson (1855:4-5) described it thus:

> Domestic life, the acknowledged foundation of all social life, has settled by a natural law the work of the man, and the work of the woman. The man governs, sustains and defends the family, the woman cherishes, regulates and purifies it, but though distinct the relative work is inseparable, - sometimes exchanged, sometimes shared; so that from the beginning, we have,

> even in the primitive household, not the *division*,
> but the *communion* of labour.

For many, then, the home changed from being the economic centre of much household activity, to a private place, where all idea of work was banished, and even the work of the house itself was conducted out of sight, below stairs.

Internal space was segregated according to function, with some rooms being demarcated for living, sleeping, or the preparation of food. It was a public demonstration of privacy, not from the outside world, but from other parts of the household - separating family from servants, parents from children.

Davidoff (1979) states that a new consciousness of privacy emerged from the end of the eighteenth century, which influenced middle class life, and helped to characterise 'genteelness'.

The layout of the middle class home was influenced by ideas about cleanliness and order, and the obsession with fresh air and ventilation (Davidoff and Hall 1987), but it was a widely held view that these values were not being adopted by the poor.

Nightingale (cited in Rathbone)[4] commented that elementary knowledge of good health was rarely known by the poor who "see comfort as an overcrowded room with no air, dirt is not a shock to them." Ranyard wrote in 1876 that one of the aims of nursing the sick poor was to teach mothers "how to avoid illness by cleanliness, good and cheap food and ventilation".[5] The Metropolitan Association, strongly influenced by the ideas of Nightingale, saw the role of a district nurse being to nurse the room as well as the patient:

> to put the room in nursing order. That is to make
> the room such as a patient *can* recover in; to

> bring care and cleanliness into it, and to teach the inmates to keep up that care and cleanliness.[6]

It was hoped that this would have the effect of transferring the values that were defining relationships within the middle class home to the working classes.

Pugh (1994) warns against being misled by the ideal of the Victorian home into viewing it as a multi-generational haven of stability. Around 90% of homes were rented by their occupants, people moved frequently, and most homes contained just two generations. Davidoff and Hall (1987) also discuss the propensity for rented accommodation among the middle classes, but add that the disadvantage of being reliant on a landlord for repairs and renovation was outweighed by the ease of moving to better premises, or a more fashionable address, when financial conditions allowed. Living in one's own home as opposed to renting lodgings was more highly prized than type of tenure. Death and desertion meant that many households were headed by a woman, and chapter 3 highlighted the number of widows active in waged work, either in the home or in formal workplaces.

The separation of home and work was not merely a middle class phenomenon, although the separation of the sexes into the public or private sphere tended to be. The production of goods at home, for instance wool production, where the wife spun and the husband wove, could not compete with industrialised processes and mass production, and so both might be forced to the cities and into the factories. Having said this, the home continued to be important as a locale for women's work, as has been stated in chapter 3, and will be demonstrated in this chapter.

The contrast between middle class and working class homes was acute (Williams 1987). Working class women were also responsible for the home, but many were also in paid employment. Indeed, Berg (1992) argues that women were employed in large numbers in the most highly productive sector of the economy (textiles), but received on average one third to one half of adult male wages for the industry, although in some areas this was equal to or above the male agricultural wage.

The changes described in middle class living arrangements led to the employment of more domestic servants, and by 1851 there were over one million (the majority of whom were women), which exceeded the number of females employed in all the textile trades. Domestic service accounted for 13% of the workforce and was part of the growing importance of the service sector (Thrift 1987:27).[7] One consequence of the increase in domestic service was the specialisation in task, or fission (Dingwall 1983), and here the emergence of private duty nurses is of interest. Female servants had frequently included the nursing of sick family members as part of their duties, but as training became more prevalent for nurses, a new worker was able to split an existing role, and lay claim to jurisdiction over the task of nursing the sick as a separate occupation. Although this demarcated the work of servants from that of nurses, as will be discussed in chapters 7 and 8 this link with domestic service had repercussions for professionalising strategies later in the century.

Albeit poorly paid, the wages of working class women could be essential to the family income, yet the middle classes often castigated them for neglecting their homes, and viewed their presence in the public sphere as contaminating and unfeminine (Williams 1987). This neglect was seen by many as the root cause

of all social ills, encouraging men into public houses, and was the underlying assumption upon which much philanthropic effort was based. In 1858 'Marion', who was the first biblewoman, invited to her home eight poor women, for whom she thought she might "do some good". They all had "bad husbands" (Platt 1939:44), but Marion told them that they could have good husbands, because:

> a kind clean sober woman almost always makes hers a good husband, but one who sits about dirty and idle and never has a clean hearth or a nice cup of tea for him when he comes in from his work, need not wonder if he goes to the Public House and spends there in one night what would keep the family for a week. (Platt 1939:45)

Rathbone described two cases of sick women whose husbands were unable to witness the misery and the household in disorder, and so turned to drink. A district nurse from the Liverpool School showed how the house could be returned to order, the men became sober again "and they and their families were saved."[8] Women were thus seen as both the problem and the solution. Housing for the working classes and the very poor varied in standard and quality. Skilled artisans could move away from the casually employed and the very poor into better housing, as their wages improved over the century, and with the coming of the 'workmen's trains'. Housing for the very poor was in cheap lodgings, sharing a room, or even a bed. There was some municipal effort in the growing towns like Birmingham and Manchester to clear slums and provide houses rather than tenement blocks, especially after the passage of the Artisan's Dwellings Act 1875[9], but this could result in overcrowding and congestion elsewhere. Tension between housing for profit, and housing to fulfil

a social need was always apparent (Williams 1987). As contractors were governed by very few regulations, the temptation to build high density housing with few amenities and little natural light, in order to increase profits, was high. Whereas houses for the middle classes were by the middle of the century being built with drainage and water supply, many working class homes had only shared facilities. Godwin (editor of *The Builder*, cited by Pike 1967:237)

described the Berwick St. area of London:

> The houses are mostly dilapidated and dirty in the extreme .... At the back of most of them .... are small, badly paved courts .... the water stands here and there in deep puddles. In the courts we saw were conveniences, a dustheap and a water tank.

This is of course the observation of someone from outside entering the court,

but there are many such descriptions. Less is recorded about how the inhabitants viewed their living conditions, or how urban living conditions compared to those left behind in the rural areas. Low wages and seasonal employment meant extreme poverty for many agricultural labourers during prolonged periods of bad weather or high food prices (Royle 1992). The Stratford Association noted that agricultural labourers have "avenues of employment partially blocked to them in winter."[10] Wattle and mud buildings, often no bigger than twelve by fourteen feet, bound together with vegetation which soon decomposed, meant that the damp, badly aired living conditions were as bad or worse than in the large towns. Many cottages were built on an undrained subsoil, leading to damp floors and moist walls.[11] In some parts of the country it was common for farm labourers to share a dwelling with livestock (Walker 1982), and overcrowding was endemic. Most overcrowding

was the result of an entire family sleeping in one room, although even the larger cottages rarely had adequate accommodation.

As Newby (1987) points out, low agricultural wages meant low rents and so there was no incentive to provide good quality accommodation. In addition owners who only had a life interest in an estate had little interest in keeping cottages in good repair. Conditions started to improve after the removal of the brick tax in 1850, but not as fast as in the larger towns.

The Metropolitan Association although identifying the need to improve the homes of the poor as a priority, recognised that this would be slow "and in the meantime the poor still have to live there and need nursing."[12] Nightingale recognised that many people thought that it was impossible to nurse the poor in their own homes, and that only by moving them from their "poor and miserable dwellings" to a hospital where they could have space, quiet and fresh air could they be cured (cited by Rathbone).[13]

Many district nursing associations gave descriptions of the conditions in which their patients lived in annual reports, and superintendent's reports to committees. In 1875 Florence Lees wrote in her second quarterly report to the Metropolitan Association:

> One room I entered with a Nurse was in such a state of dirt and chaos, that at our first visit we were almost in despair where to begin .... all soiled linen, unused garments, odds and ends of every description, had been piled under the bed. Sufficient to say that we cleaned the room.[14]

In Oxford, too, the 1883 annual report of the Sarah Acland Memorial and Home for Nurses[15] commented that:

> those who only see the principal streets of the city can have little idea of the miserable homes in which many of the poor live, nor of the extreme poverty of numbers of the people. Sickness, always trying, is under such circumstances doubly so. .... The filth and neglect encountered are sometimes indescribable and appalling.[16]

It could be argued that if fund-raising was the object of these reports,[17] then perhaps a colourful description was thought necessary to elicit donations, but they are consistent with the experience of Mary Cadbury, a Nightingale nurse who was, for a few years, a district nurse in London and Liverpool. Her descriptions of the homes she visited are contained in letters to her family. In 1879 she wrote to her mother:

> One of [my cases] was a child of two with inflammation of the lungs wanting poulticing back and front. The child is very ill and hardly likely to live and the mother is very broken hearted about it, a very miserable home in a court out of Grays Inn road, just one room very dirty and untidy. They are people much reduced and I think the father must drink. My other case was a great contrast though the accommodation just about as small, but beautifully clean and well, two small rooms over stables through which we have to pass and up the rickety stairs. .... The beds are generally so hard to make, all in a corner and no possibility of getting to the other side and large feather beds. I wonder what you would say to the places we often have to go into, at night especially, groping our way in the dark up the winding staircases to the very top.[18]

It was also considered the duty of the district nurse to report any sanitary defects in the homes they visited to the attention of the public health department, and as Nightingale wrote to Henry Acland in February 1884 "this is not even of secondary importance to the nursing: this is must not may. This

the District Nurse and her head must do or have their nursing rightly condemned as almost worthless."[19]

Towards the end of the century the poor, too, were leaving the inner cities, but unlike the middle classes it was not from choice. Central land was becoming more valuable and workers' housing was cleared to make way for high value shops, offices and public buildings (Dennis 1984). These would then be near to the railways, which had also displaced the working class population earlier in the century (Aldcroft 1992).

This section has been concerned with the delineation of home as both a physical and social structure. The transition, it has been argued, was a consequence of the rise of capitalism, the new middle classes which emerged gaining status from an alteration in the role of women to a more leisured existence. The idea of a 'communion of labour' which demarcated male and female roles reinforced this position, but also opened up the possibility for women to lay claim to those female roles in the public sphere, as well as in the home. This will be explored later in this chapter. Capitalism did not have the same impact on the lives of working class women, in that although they too were expected to be home centred for many this was only possible by incorporating some form of wage earning into domestic duties.

Gender and the role of women

The consequences of the delineation of home into both a physical and social structure on the lives of women will be explored in this section. As was argued above, the sexual division of labour, which ascribed to women specific roles associated with home making and child rearing within a patriarchal power

structure, was applied differentially, and the life of the working woman was very different from that of her middle class counterpart. Therefore, each will be considered separately.

Chapter 4 highlighted the change in the lives of many middle class women during the emergence of separating spheres of the home and the workplace. Vicinus (1972:ix) differentiates between the perfect wife of the early nineteenth century who would contribute to the family income, either directly or indirectly, and the perfect lady of later years, an ideal "which had little connection with any functional and responsible role in society". The world of many middle class women became the private sphere of the home, while men went out into the public sphere of the workplace. Women had been excluded from the franchise by the 1832 Reform Act, which meant that their opportunities outside the home were extremely limited (O'Brien and Penna 1998).[20] They were frequently perceived as delicate and prone to illness, which helped to legitimate their restriction to the private sphere (Williams 1987). This legitimisation was strengthened by contemporary medical discourse, with its claim to scientific rigour, which both reflected and contributed to dominant thinking.

It was regarded as a sign of wealth and gentility for women not to have to contribute to the family income, and Summers (1990:124) described them as "emblems of the worldly success of their male kin."

From the middle of the century there was also an excess of women over men in the population, caused by greater death rates and emigration among men. This was perceived as a 'problem of surplus women' (Worsnop 1990) who would never marry, and yet in the case of middle class women their upbringing and

education had concentrated on preparing them for the role of wife and hostess. According to Jameson (1855:60-61) education for women "is merely calculated to render them ornamental and well informed; but it does not train them, even those who are so inclined, and fitted by nature, to be effective instruments of social improvement." These 'surplus' women were often called upon in emergencies, and Davidoff and Hall (1987:435) describe the life of Rebecca Kenrick of West Bromwich, whose "life was spent travelling between family and friends, giving help where it was needed." For women such as this volunteer labour may have been conducted as part of an exchange system, based on board and lodging, and companionship, rather than money. In this case there would be a blurring of the edges between the subjective and the informal economies, as more than a symbolic reward is gained. A non monetary exchange is occurring, on an informal basis. Yet the position of Rebecca Kenricks and her like is not analogous to the housewife, as there is no obligation on her part to offer her labour.

Although working class women were assumed to be in employment as domestic servants or in the mills and factories and therefore capable of supporting themselves, it was assumed that middle class women would be supported by a man - usually a husband or father. The 'problem' was highlighted by the 1851 census which for the first time published information on the age, sex and 'conjugal condition' of the population (Worsnop 1990). There was said to be an excess of more than half a million females over men - 104 women for every 100 men (Jameson 1855). This prompted radical contemporary writers, such as Leigh-Smith (cited in Worsnop 1990), to redefine the problem not as one of surplus women, but as one of lack of

educational and employment opportunities, and to press for the extension of social, political and employment rights to include them.

Jameson (1855:9-10) sets out the issues thus:

> The great mistake seems to have been that in all our legislation it is taken for granted that the woman is always protected, always under tutelage, always within the precincts of a home, finding there her work, her interests, her duties and her happiness: but is this true? We know that it is altogether false. There are thousands and thousands of women who have no protection, no guide, no help, no home - who are absolutely driven by circumstance and necessity , if not by impulse and inclination, to carry out into the larger community the sympathies, the domestic instincts, the active administrative capabilities with which God has endowed them; but these instincts, sympathies, capabilities, require, first, to be properly developed, then properly trained and then directed into large and useful channels, according to the individual tendencies.

Jameson, unlike Leigh-Smith, did not advocate women's inclusion into what had been male preserves, but accepted the 'separate but equal' philosophy of gender roles, which was highlighted in chapter 1 as a commonly held view, but one which was shown to be problematic for women in the public sphere. It did not address patriarchal relations, but concentrated on task distribution by gender as defining the sexual division of labour. In demanding its extension into public life women were accepting the institutionalisation of existing patriarchal power relationships (Gamarnikov 1984).

For example, although in 1848 the newly appointed Lady Superintendent of St. John's House was responsible for the nurses, she did not believe that ladies would enter the institution without the authority of a male head, and allowed

her authority to be subjugated. In describing her role in relation to that of the Master she stated:

> It would seem essential to good order that where two are jointly placed in authority over others one should be head and principle, and when one of the two is a man and the other a woman the spirit of St John's injunctions that the woman should not teach - should not usurp authority should be in silence - would seem to require that she should hold the second rather than the first place.[21]

Even where men did not take charge of district nursing associations, the committees which made financial decisions, and rules and regulations for the conduct of the nurses, were overwhelmingly male. This division of labour in philanthropic societies, where men were involved in decision making and women undertook the 'hands on' work was common, again reflecting prevailing patriarchal relations. The exception to this was the Ranyard Mission, whose organisation remained 'for women, by women'.

The response from many male commentators regarding the increasing involvement of women in the public sphere is summed up by Worsnop (1990:26)

> This widening of women's occupational opportunities was perceived as an encroachment on male preserves and the conservative responses continued to argue for the maintenance of an ideology of domesticity which bound together women, marriage and dependence.

Many women did, however, reject the notion of domesticity and move into the public sphere, although finding suitable occupations which would accept women was not easy. Nursing was an exception, as it provided for women an

uncontested jurisdiction over which they could lay claim. However, as Abott notes, this was only a limited settlement, with nursing subordinated to medicine.

As argued in chapter 1, part of the rationale of some nursing reformers was to raise the status of nursing to a level which would make it a suitable occupation for middle class women[22]. As the draft report of the Metropolitan Association states:

> Everyone knows .... how few employments there are open to gentlewomen. An officer, clergyman etc., can bring his sons up to earn their own living in the world, with the hope of their leading useful lives to the community at large, perhaps of rising to honour and renown. But what provision can he make for his daughters? As children they have probably received a far less thorough and expensive education than the sons, on the assumption that it will be of no use to them when they are grown up. The father dies, and with him, probably, all the little 'means' his family possessed. Untrained and half educated his daughters must go out into the world to earn their own living as best they can. And the only way open to them is to become a 'companion' or 'governess'.[23]

Similar arguments were put forward by Southey (1829) *inter alia*.

Prochaska (1980) is struck by the way that so many women managed to lead independent lives, despite the pressure of convention, and Summers (1990) notes the often heavy personal cost in the alien and hostile environment of the public sphere. Indeed, Branca (1975) questions whether the stereotypical leisured and dependent Victorian woman ever really existed.[24] The 1884-85 annual report of the Derby and Derbyshire Nursing and Sanitary Association[25]

reported on the death of Miss Brumwell, who had been its lady superintendent for sixteen years, and described her as:

> a lady of independent means, preferring a life of active usefulness; having a decided taste for nursing, and specially for work among the poor; of good judgement; of inexpensive habits; with special powers of administration in giving relief, and in helping the poor to help themselves.[26]

Similarly, Mr. Mocatta, at the 1890 AGM of the Metropolitan Association stated:

> Many of the nurses of this institution were ladies with good incomes of their own, who had taken up nursing for the love of it, and with a desire to do a woman's part in tending the sick and afflicted, for a refined mind nursing was a noble duty, calling into exercise all the powers of the mind and body to alleviate pain and suffering.[27]

These observations would suggest that although middle class women were becoming more accepted in paid occupations by the end of the century, they were being judged by different criteria from men. Early domiciliary nurses in Sisterhoods were expected to demonstrate characteristics of service, obedience and dedication, and these same characteristics were later valued in women who were being paid and developing careers in the official economy, a seemingly anachronistic position. The idea of vocation was a feature of some women's occupations, but of no men's with the possible exception of the clergy. Indeed, one of the advantages of district nursing for middle class women, put forward by Dr. Cheadle in 1891, was that it not only enabled them to maintain themselves, but because of the training and discipline they received they were better fitted than other women for the duties of life as wives and mothers.[28]

Freidson's (1978) typology of occupations does not really include vocation, it is rather subsumed into the subjective economy. Vocation, at least in the way the concept has generally been utilised within nursing, moves beyond the subjective labourer's commitment to the work for its intrinsic value, to the subjugation of self into a subservient and obedient being. This so fitted the ideal of Victorian womanhood that it was exclusively associated with female occupations. When paid work is added to the idea of vocation, as in all forms of nursing, then a fusion of the official and subjective economies occurs, creating a hybrid which was typical of female occupations. This idea will be developed in the following chapter.

More women found an outlet for their energies in philanthropic activity than in paid work, as this provided an acceptable alternative. They could carry out from altruistic motives what they could not be paid to do. Vicinus (1972) views charity work as being an outlet for the passions of a group of women who were expected to be loving and emotional, and yet without sexuality, and Gerard (1987) argues that only in philanthropic work could many women achieve independent action and power over the lives of others. She also suggests that it could provide a form of escape from an unhappy marriage. Davidoff and Hall (1987:436), however, dispute the amount of philanthropic activity carried out by middle class women and call it "a minority choice", and indeed district nursing charities often appealed for more middle class 'lady' volunteers to help in their work. There were never enough lady superintendents, for example, to pair with every Ranyard nurse, as was originally intended, and Rathbone found that because of the money required to provide 'comforts' there were not that many suitable lady superintendents for the Liverpool School.[29] Prochaska

(1980:224) on the other hand, argues that "given the number of women active in philanthropic work, the idea of the idle Victorian woman is difficult to sustain", and from the literature this would appear to be the dominant view. Prochaska (1980:6) states that charity work was "relatively free of the restraints and prejudices associated with women in paid work." However, as Summers (1979:33) states, for women philanthropic work "was not just the dilettante fashion of passing free time, but an engagement of the self which involved the sacrifice of leisure and the development of expertise." This work by women illustrates the inadequacy of paid employment as the definition of work. Their role in the subjective labour force was an important facet of district nursing associations, many of which could not have survived without it. Summers also points out that while the philanthropic pursuits of middle class women indirectly contributed to their emancipation, they were often diametrically opposed to the emancipation of the women in social classes beneath them.

McCarthy (1990) also views nineteenth century American philanthropic work in a positive light, stating that women used it to wield power in societies which render them powerless, forging parallel power structures to those used by men, and creating an enhanced public role for themselves. She adds that it gave them a foothold in public policy making, and that those who stayed within the philanthropic/charity sphere were not accorded the derision that more educated women often received when attempting to enter the public sphere. This concurs with Summers, and accords a seriousness to an activity which is often trivialised. McCarthy notes the need for suitable paid careers for middle class women in the middle of the century, a recurring theme in this thesis, some of

which emerged out of philanthropic pursuit. Prochaska (1980) also believes that women's prominence in philanthropic work paved the way for their acceptance as paid officials in traditionally male occupations, such as Poor Law Guardians, although it simultaneously highlighted the limitations placed on women.

Williams (1987:196) adds a note of scepticism when he points out that live-in servants of middle class families usually occupied "rather mean accommodations" in attics or cellars, and Grint (1991) notes that domestic servants were exempt from factory legislation.

Daniels (1988) in writing about late twentieth century America discusses the inter-relationship between a woman's voluntary work and her husband's career. A man's status is significant in his wife gaining entry into prestigious associations and social networks. Once admitted, a wife can use the contacts that it affords to advance her husband's career, for instance by introducing prospective clients. It is possible that extrapolations can be made to suggest that although women's philanthropic work in the nineteenth century was undervalued, it in fact had this secondary, undocumented consequence. Daniels calls this work "female entrepreneurship." McCarthy (1990) makes a similar point regarding the effect of female philanthropic work on a husband's political career in Latin America.

Prochaska (1980) states that the type of visiting conducted by middle class women, and the help given reflected the type of education received by them. Most did not question the social structure of society or the economic organisation, but tended to accept the *status quo*. Dealing with immediate problems by short term solutions was the main form of intervention. He also

points out that apart from an aversion to state provision of welfare, which conformed to dominant thinking of the time, many women opposed it for rather more pragmatic reasons. Any government involvement in welfare at a time when women were largely excluded from the public sphere would have heralded a decline in female influence. One of the few outlets for them could have been closed.

As working class women were castigated for working outside the home, so middle class women carrying out charity work were similarly criticised by those who thought that they, too, were neglecting their duties to their families. There was also criticism from those retailers who saw their trade decline when 'ladies' sold the same goods for fund-raising, as well as from those who thought that ladies should not be involved in trade for any purpose (Southey 1829).

Middle class women, then were increasingly rejecting the role expected of them as home centred wives and mothers, but within the context of the patriarchal family. For many this was not choice but necessity. The professionalising occupations of the period were closed to them because of these role expectations, and because credentialist tactics were frequently being used by the emerging professions as exclusionary strategies. Women's education did not equip them to compete, even if the gender division of labour had not precluded public life. There were, therefore, dual strategies of exclusion and segregation working against women in the public sphere. The influential concept of communion of labour challenged the former, but accepted the latter. We have, then, the existence of a potential supply of labour with limited scope to enter public life. For the most part this supply did not need to earn an

income, indeed financial reward could be seen as a positive disadvantage, by de-classing the labour. Subjective labour was a symbolic, but visible demonstration of the absence of need to earn an income. Whether in the form of philanthropy carried on from within the constraints of the patriarchal family, or via vocation, such as was to be found in the Sisterhoods, it also provided an acceptable form of occupation.

If middle class women were "pure but sick", working class women were "contaminated and sickening" (Duffin 1978:31). The exclusion of women from the public sphere did not include them,[30] and as previously stated they were employed in large numbers as domestic servants (doing public work in private places) and in some industries, notably textiles. Walby (1990) argues that this produced a tension between capitalism and patriarchy, as employers wished to exploit female labour, which was cheaper than that of men, whereas patriarchy wished to exploit female labour within the household, especially in childrearing once mechanisation had made children unnecessary in the productive process. Grint (1991:79) adds "the moral economy that supported the patriarchal family was a critical resource in the demise of employment for married women and children." This was exemplified by the 'family wage' campaign, in which men attempted to secure a high enough wage to maintain a family, thereby negating the necessity for married women to carry out waged work, and securing the authority of the male.

The extent to which women were engaged in active waged work was as high in the mid nineteenth century as in the middle of the twentieth, at forty three per cent (Hakim 1980). Married women and widows show similar trends to single

women,[31] and reference has already been made to the overlap between domestic tasks and paid work, such as taking in washing. The pattern of female employment varied according to the local economy, textile areas having a high female workforce and mining areas a low one (Pugh 1994). In the early industrial revolution spouses and their children worked in the same place, so that the family was relocated from the home to the factory, where men could control their families, and employers the whole family (Williams 1987). The situation changed over time to that described by Pugh as male workers came to dominate the manufacturing process.

If the poor were held to be responsible for their own conditions, blame was most frequently laid at the door of women, as illustrated earlier, especially those who worked outside the home. Scott (1993:400) states that arguments in the debate surrounding women workers were framed in terms of an assumed opposition between "home and work, maternity and wage earning, femininity and productivity." It has already been argued that working women were perceived as neglecting their domestic duties, and this was said to encourage men into public houses. Factory workers were particularly singled out for criticism, as the heat generated and the proximity of men was held to lead to depravity (Williams 1987). They were also criticised for working until the very late stages of pregnancy and returning to work soon after giving birth, thereby producing underweight children who were often left in poor quality child care, leading to the premature death of many infants. Although there was evidence of the adverse effects on survival of mothers working outside of the home, the necessity for women to continue in waged work in the late stages of pregnancy was rarely questioned, the economic organisation of the country being

uncritically accepted. Similarly, women's ability to maintain a clean home and tidy children with no water supply and little money for fuel was rarely addressed. 'A Physician' writing to Nightingale in 1860 dismissed the giving out of tracts by the London Ladies Association because "the poor, with untrained intellects, are unable to comprehend or follow written arguments, however plainly stated."[32] District nursing associations commented frequently on the inability of working class women to keep house or follow instructions given by doctors regarding the care of the sick. Ranyard, for example, often wrote that the poor required teaching in order to nurse themselves and their children. Examples of this perceived basic lack of knowledge appeared in *The Missing Link*,[33] including the story of a child with a chest complaint for whom a doctor had prescribed a plaster. A neighbour made the plaster of pepper, mustard and vinegar, which was so hot that by the time the child was seen by a nurse it had caused a big open wound to develop.[34] A nurse from the Liverpool School reported that "The people whom I have had to do with are most of them so ignorant that they do not know how to take care of themselves or even to prepare the common necessaries of life."[35]

Williams (1987:182) comments that "the overwhelming power of middle class values in this era makes it difficult to extract the realities of working class family life." It is important to note that much of what is written about the poor and working classes has been written by middle class commentators, and that their own perspective on their conditions is rarely sought.[36] There is, however, evidence that working class women balanced the benefits of accepting help and advice with the costs in terms of the welfare of the family. For example, in

order to take one child to a clinic other children may have had to be left alone, or wages may have been lost (Ross 1990).

Commentators such as Bosanquet (cited by Lewis 1992), saw women as possessing skills and a sense of responsibility enabling them to improve the living conditions of the family in the face of adverse circumstances. Ranyard, too, believed that if anything was going to help the poor it had to be achieved through wives and mothers (Platt 1939). The means of improvement was therefore in their hands, and many philanthropic societies targeted women, leading Alexander (1976) to comment on the relentless scrutiny of working class women by the middle class. Although women had always been economically productive, Scott too (1993:399) points to the fact that in the nineteenth century they were "observed, described and documented with unprecedented attention as contemporaries debated the suitability, morality and even the legality of [their] wage earning activities."

The delineation of home into a physical and social space influenced the opportunities for women to enter the public sphere. For both middle class and working class women these opportunities were defined by the gender division of labour, or what was more commonly regarded as the communion of labour, which emphasised task distribution by gender. Nurturing and caring were seen as naturally female preserves, whether undertaken in the domestic or public setting. For middle class women subjective labour, in the form of philanthropy, provided an acceptable form of occupation. For many working class women going into the workplace, or incorporating wage earning into the domestic role was a necessity. Moreover, images of working class women neglecting their families because of their waged work provided a focus for the subjective labour

of middle class women. This opened up an area of work which could form an uncontested jurisdiction, since it was also women who were expected to take responsibility for improving the moral culture.

Philanthropy

I have argued that the lives of middle class and working class women came together as the result of philanthropic endeavour. The rest of this chapter will elaborate on this, specifically focusing on district nursing as an example of such philanthropy.

Donzelot (1979) differentiates between charity, which was the giving of material aid in times of misery, and philanthropy, which was more pragmatic and centred around advice, in the hope of averting expense by behaviour change. Lewis (1995), however, cites the Charity Organisation Society (COS) in describing charity as having a social purpose, not being merely the giving to the poor by the rich. In dictionary definitions and common sense usage the terms are often used interchangeably. For the purpose of clarity, Donzelot's differentiation will be utilised in this thesis.

Philanthropy was the interface between the lives of women who would never otherwise meet, except as mistress and servant. This was a particular feature of the nineteenth century, and an explanation is required as to why this was, and why it was women who were most involved.

Why was philanthropy a striking feature of nineteenth century life?

The massive social changes brought about by the industrial revolution needed some rationale, as an understanding was sought for what was occurring (Fraser 1984). Industrial capitalism was justified by what came to be known as classical

economic theory, with its doctrine of *laissez faire*. In this the best and most efficient way of conducting business was free trade unhindered by government regulation, which would lead to the production of the optimum number of goods to ensure sale at a profit. Regulation would be via competition, and self interest and self help were the guiding motivation. Essentially, these were the ideas proposed by Adam Smith, whose work *An Inquiry into the Nature and Causes of the Wealth of Nations*, published in 1776, was to become highly influential in the formulation of nineteenth century social policy[37]. It heralded a move away from mercantilism, which was more interventionist and protectionist in approach (Fraser 1984). These arguments were very plausible, as living standards, as noted in chapter 4, did rise overall during the nineteenth century, and most individuals had a better standard of living at the end of it than had their forebears at the beginning.

This liberal philosophy extended to the provision of welfare. The state was thought to have little role in its provision, as it created dependency and a disincentive to work. This idea reflects Liberal interpretations of Enlightenment, such as those espoused by the philosopher Locke, which emphasised free will and self interest as characterising human activity. Liberal philosophy on welfare, however, is not monolithic and O'Brien and Penna (1998:16) describe it as "complex amalgams of radical and reactionary, progressive and regressive elements, referring back to the past and forward to the future, at some times stressing freedom, at others emphasising constraint." The state's involvement was mainly via the Poor Law[38], which was meant to act as a deterrent to the workshy or fraudulent by institutionalising the able bodied poor. The doctrine of 'less eligibility' applied, whereby conditions

experienced within poor law institutions were to be worse than those of the poorest labourer outside. There was, however, great diversity in the extent to which the doctrine was applied, and outdoor relief continued to be given to the able bodied (Royle 1987). O'Brien and Penna (1998) describe the first half of the nineteenth century as encapsulating a minimalist concept of society, and focusing on the progress of an abstract 'whole'. This can be contrasted with second wave liberalism, which was more influential towards the end of the century, and which accepted that complex societies could not be left unregulated. State involvement in welfare was viewed as a necessary evil. These tensions within liberal philosophy can be seen in the different attitudes towards relief giving in district nursing associations.

In 1862 Ranyard wrote:

> the charities of London are its curse .... dependence on chance favours destroys industry and virtue; and the truest aim of a benevolent heart must be to help the people to help themselves if we would not increase and prolong their misery. (cited in Platt 1939:16)

In later years, however, more gratuitous relief does seem to have been given by the Ranyard Mission in those cases regarded as deserving, reflecting the move to second wave liberalism described by O'Brien and Penna (1998), as in the case of Mrs Smith, a paralysed woman found lying in a cold room with no blanket:

> she told us that she had a good blanket, but during the summer she had been obliged to 'put it away'. We enquired how much it would be, and on hearing that it was only 1/9d sent her grand daughter to fetch it.[39]

She lived with a son and his wife, who were in debt because of having a large family, but who were described as "striving, industrious people."[40]

Nightingale, too, was very critical of relief giving, and also pointed out in a letter to H. W. Acland[41] in 1884 the incongruity of the relationship between the Poor Law and charity:

> The 'non - sens' in England which you are perpetually meeting with, and in no other country is: you organise an immense Poor Law machinery and then you organise charitable machineries without number, to keep people 'off the poor law'. If the District Nurse did nothing else but utilise the parish authorities to keep the sick 'off the Parish' and out of the workhouse - to depauperise them in fact - it would be a thing well done.[42]

The bulk of welfare was provided through voluntary agencies and philanthropic pursuit. Philanthropy was felt to be superior to state provision, as private individuals and societies were better able to discriminate between the deserving and the non-deserving poor, and to channel aid to the former. They could also set conditions for the giving of aid, and monitor the use to which it was put. Gerard (1987) adds that private charity demonstrated the giver's superiority and the recipient's dependence, and it could be used to reward the suitably deferential.[43] Fraser (1984:124) has commented on the "phenomenal variety and range of Victorian philanthropy", which in London, and possibly other conurbations, exceeded the annual spending of the poor law authorities, and O'Brien and Penna (1998) add that because of charitable giving more than four times as many people received relief outside of the workhouse than inside.

Rathbone, in 1865, wrote that the provision of district nursing would repay the ratepayers of Liverpool by the reduction in the amount of pauperism, yet he did

not believe that it should be organised by parishes. His argument in justifying the organisation of the Liverpool School encapsulates the ideology of philanthropic welfare:

> For under a system of parochial payment we should lose the best and most useful accompaniment of private charity, the personal interest and superintendence of givers. So long as the nurse is supported by private benevolence, she and her patients enjoy the estimable advantage of the control, advice and aid of educated and refined women, who naturally undertake the supervision of charity for which they provide the means, but who would be neither able or willing to interfere if the nurse were a parish officer and the nursing and food and medicine supplied by parochial funds.[44]

Moving to the second question posed at the start of this section, why was it women who had the greatest involvement in philanthropic pursuit?

As we have seen, middle class women had free time to get involved in philanthropic activities and relatively few legitimate outlets for public life, but although this was a necessary condition it was not sufficient to explain why it was *women* who were most involved. Prochaska (1980) notes that women saw more of disease than men, and that they often took on a new piety after witnessing a death. It was after such personal experience that many women became involved in philanthropic visiting. It was said to be Elizabeth Fry's habitual acquaintance with the sick room, and with suffering and death which led her to identify the need for "a class of woman superior to the hireling nurses generally obtained."[45] Jameson (1855:11), however, considered that the potential of women was not realised and was "not only neglected, but absolutely ignored by those who govern us."

It was women whose civilising influence was expected to improve the moral qualities of both men, whose desires were held to be innate and uncontrollable, and also of servants, by teaching them how to perform their household duties. Servants were expected to carry these lessons into their private lives, thus espousing the values of the middle class. Taking these lessons into the homes of the poor would seem to be a natural extension of the work women were doing with their own servants. At a time when men were losing social relationships across class barriers at work, women were gaining them by the employment of servants (Summers 1979). The Victorian middle class home, therefore, had a role concerned with relations within and between social groups, being the meeting ground for the different classes (Williams 1987). Davidoff and Hall (1987) argue that in smaller towns and rural areas philanthropy was linked to the family of an employer, and Gerard (1987) points to the informal face-to-face charity that was seen as a public duty of landowning classes. In large towns, however, these paternalistic practices were hard to recreate, and much philanthropic work was not based around the workplace. This may help to explain the initial growth of district nursing associations in large towns and cities, the impetus coming mainly from doctors, clergymen or people involved in other philanthropic work, who then formed committees to deal with the organisation and management.

Causes of poverty were not investigated until late in the century, and it was largely held to be the result of indolence or improvidence. The idea of 'character' as moral qualities was prominent in Victorian political thought (Collini 1985), epitomised by hard work and self reliance. It was character (or lack of it) that was held to constitute the difference between the rich and the

poor. For Florence Nightingale character was the most important attribute of a nurse.[46] Middle class reformers were more concerned with disease and contagion than the nature of poverty and exploitation (Williams 1987), presumably because of the risk to themselves. Charities varied in the amount of gratuitous relief they provided, but evangelical societies particularly refused to give relief, preferring to provide loans or conditional relief in order to help the poor to help themselves.

Notwithstanding the case described above, the Ranyard Mission would normally only consider relief that would help the recipient into independence, as in the case of a recently widowed woman with two children:

> [She] is a hard-working woman, and means to earn her living by washing or else mangling. She has heard of a mangle and of a business to be had and I said, if all seemed promising, I would guarantee the money.[47]

In addressing the Liverpool Women's Conference in 1891, Emily Minet stated that the principles on which district nursing should be based were:

> principles which, I conceive, should form the basis of all philanthropic work and without which the action of philanthropy must cause more evil than good. .... self-knowledge, self-reverence, self-control .... self-help and self-reliance. Any form of philanthropy which weakens these qualities .... in other words does for a man what he should do for himself is therefore bad.[48]

These ideas were crystallised in the philosophy of the COS,[49] founded in 1869 to provide "a division of charitable labour" (Bosanquet 1874:12), which attempted to take a scientific approach to the organisation of charity, advocating self help and sacrifice on the part of the poor. It investigated

applicants for relief, and would only undertake casework with those deemed 'deserving', assisting with employment and encouraging thrift, and only giving material relief as a last resort (Lewis 1992). "Cases" deemed beyond "cure" were referred to the Poor Law authorities (Bosanquet 1874:6). Its approach of social administration and surveillance provided a moral paternalism, which was, nevertheless, consistent with liberal philosophy.

By the 1880s the philosophy of the COS of working with the deserving poor in an attempt to move them into self sufficiency, a stance that had influenced many charities, was coming under increasing criticism. This position had remained tenable during the period of relative affluence which followed the Great Exhibition, but rising unemployment and levels of poverty made private philanthropy appear inadequate to deal with the scale of need. (Pugh 1994). There was also a major reorientation in attitudes towards the poor and the causes of poverty which, Jones (1971) argues, contributed to the removal of the COS from the centre of the debate. Lewis (1995), however, states that the COS remained influential until the first World War, despite this shift. Its influence on the Royal Commission on the Poor Law, would suggest this to be the case, at least in the eyes of government.

District nursing associations had different opinions on whether relief in the form of food should be treated differently from other forms of relief. Ranyard nurses rarely gave food, as not only did it run contrary to the doctrine of self help, but it was felt that it did not always get to the sick person. The Derbyshire Association did give relief, including food, although the annual report of 1869-70 stated that "we are fully aware of the danger of nursing among the poor becoming simply a distribution of food." Usually the poor sent for the food

themselves and it was given "according to the judgement of the lady superintendent."[50] Over the years, though, the association seems to have become convinced of the value of food relief. In the 1877 annual report it was argued that food for the sick poor and their families was seen as saving whole families from the workhouse, by keeping up their strength, which was preferable to trying to rescue them later.

St. John's House saw food as necessary to convalescence, and between 1867 and 1883 it cooked and distributed twelve diets daily for out-patients from Charing Cross and King's College Hospitals, the recipients being selected by the doctors. Convalescent patients received meals in the 'Poor Hall' at the Norfolk Street premises, and they were also visited at home. The system ended because of lack of funds.

The Reverend Daniel F. Sandford, on his resignation from a parish in the East End of London, wrote about the district nurse from St. John's House working in the parish, that she gave 'comforts', clothing, surgical appliances, books, pictures, fruit, flowers, coal etc. She distributed alms to homes where the breadwinner was sick, and all from contributions.[51]

At the Stratford upon Avon Nursing Home and Children's Hospital[52] the Lady Superintendent was responsible for the relief of the sick poor, within available funds. "By this means imposition is avoided; the sick get what is ordered for them; the poor are no longer sent to public houses for stimulants; and the benevolent can always hear of well deserving cases on which to bestow charity."[53] Sick diets were dispensed from the home's kitchen, the cost being met by parochial funds and private benefactions.

Nightingale, however, thought that it was not the duty of district nurses to provide any relief, and argued strongly in her correspondence that it should be solely a system of nursing. She wrote to H. W. Acland in 1884:

> With regard to District Nurses giving anything to patients beyond actual nursing: people of experience doubt there being any districts especially in London where the wants of destitute (or very poor) sick e.g. as to food and clothing (not cooking) cannot be supplied by the various agencies which abound - too much almost - in London if applied to by the nurse or her head.[54]

The availability of charitable relief in London was derogated by the Ranyard Mission in 1885, which reported stories of people refusing the help of bible nurses on the grounds that it would reduce their ability to obtain charity. On asking a patient whether he would like a bed and bedstead a nurse received the reply "Who do you think 'ud help us if we'd got a bed and bedstead? It's being on the floor that does 'em. We don't want no bedstead."[55]

Nightingale and others saw the success of the Metropolitan Association being "to drag the noble art of nursing out of the sink of relief doles."[56] This was often used as justification for only employing educated ladies as nurses, or as superintendents.

In the early years of the Liverpool School many untrained nurses were employed, often due to the preference of the Lady Superintendent of the district, and in 1869 Charles Langton wrote to Henry Bonham Carter that this resulted in more relief than nursing.[57]

There was a recognition that towns and cities outside London may not have the charitable agencies to provide help to the needy, and the report of the sub committee of the Metropolitan Association stated:

> The London system is justified in not giving any relief by the circumstances in London with an enormous number and variety of charities, whereas the Liverpool system is more suited to large provincial towns.[58] ....
> Liverpool with its district home with 6-8 nurses with a trained professional superintendent and a Lady Superintendent to obtain comfort and relief suit the provinces where charities are less numerous, and there are less ladies to do the nursing.[59]

By the 1880s educated ladies were being employed in Liverpool, and Rathbone justified this in the 1881 annual report of the Metropolitan association:

> Apart from improving nursing it had also been influential in diminishing the amount of relief given by nurses, which at one time threatened to turn nursing away from its proper course, and to demoralise the professional part - the real nursing of the sick in their own homes.[60]

The issues, here, are whether relief should be provided at all, and whether district nurses should be involved in its provision. From the discussion so far it can be stated that although the dominant ideology of the time would suggest that it should not, compromises were made to meet specific individual and geographical circumstances. As to the question of whether district nurses should give material relief to their patients, although from the annual reports and correspondence of those making decisions over the nurses' work it can be assumed that there was widespread conformity to the liberal view of welfare, later in the century ideas about what were appropriate tasks for professions to

be undertaking may have influenced some associations. This will be considered in chapter 8, but it is worth noting here that not giving relief became an important defining factor in professionalising projects of district nurses at the end of the century.

In keeping with the spirit of self help some associations asked patients to contribute to costs of some goods and services according to their means. So in Derbyshire 'Mrs C' was given food and old linen, and 'Mrs G' was provided with a woman to help with washing once a week, but the convalescent fund for sending patients to the country or the coast was allocated according to patients' means, "it being the object of the association to help the poor to help themselves."[61] It was felt that people valued the gift when it was supplementary to their own efforts. In 1882 the committee of the Metropolitan Association instructed the superintendent to make a small fixed charge for nurses' services, where the patient's circumstances warranted it. "The moral effect of encouraging small payments and voluntary offerings will not be without some weight in inculcating the principles of self help."[62] More pragmatically, "it will commend itself to the sympathies of those who desire to see the self supporting principle used more widely."[63]

The previous year the association had made arrangements with the Metropolitan Provident Medical Association whereby for a small extra payment members could have the services of a district nurse. This did not prove very popular, but the idea of provident associations for the supply of district nurses was more commonly used outside London towards the end of the century. The Acland Home, for example, believed that as the knowledge of sanitary science increased with the education of the people, some of the work being undertaken

gratuitously would be done on co-operative principles by provident dispensaries "To prepare the way for such improvements is truest charity."[64] Hurry (1898) also advocated the greater use of provident societies. Whilst acknowledging the need for district nursing for the sick poor, he questioned whether it was organised in the best way. He estimated that the poor constituted eighty per cent of the population, but that a great need had not been supplied, and what there was did not promote a habit of thrift and self reliance. Because district nursing was mainly established on a charitable basis, funding being raised by the subscriptions and donations of the upper and middle classes, dependence on gratuitous help was encouraged. "[T]hese institutions tend to demoralise instead of fostering a spirit of self help and thrift" (Hurry 1898:18) He argued that the vast majority of the poor could pay something and ought to. For the destitute, the Poor Law Guardians had the power to supply nurses or pay provident societies to provide a service.

The solution that Hurry proposed was the establishment of provident societies similar to provident dispensaries and medical societies, with weekly or monthly payments entitling the subscriber to a nurse during sickness. This would create financial stability for the society and encourage thrift among the members. The service could be added to existing provident dispensaries or friendly societies for an increased sum. A capital sum would need to be raised in the first instance to provide a home and to pay wages and purchase appliances before the subscriptions were high enough. Examples of provident district nursing associations will be discussed in chapter 7.

Conclusion

This chapter has discussed the symbiotic relationship between women, home and philanthropic pursuit, the nature of which is historically specific. It has argued that the delineation of home into a physical and social space influenced the opportunities for women to enter the public sphere. These opportunities were circumscribed by a definition of the gender division of labour which focused on task distribution, but accepted uncritically existing patriarchal power relationships. Women did not for the most part seek inclusion into the expanding professions, which were closed to them, but argued for the extension of women's 'natural' role as carers and nurturers into the public sphere.

For middle class women, philanthropy provided the vehicle by which this could be achieved. If women could not enter the official economy, the subjective economy provided a legitimate outlet for public work. Philanthropic effort had elements of religious zeal, social control and a genuine desire to help the poor improve their conditions, without altering existing social structures. These elements coincided in the nineteenth century to produce a type of welfare that was fairly unique, on such a large scale, to the period, and symbolised the transition to modernity. District nursing was one facet of this, the emergence of an occupation which had found a niche in carrying out work that had previously been done by family and friends. The categorisation of nursing as women's work facilitated a 'taken for granted' and uncontested jurisdiction. Although there was not the same prohibition on working class women entering the workplace, censure was applied in the form of exhortations for them to stay within the home to care for their families. For many, however, some form of

wage earning was a necessity. Here gender divisions can be seen to be subordinated to class divisions, as the perceived problems created by working class women in waged labour provided the rationale for much of the subjective labour of middle class women.

Women, whether active in the official or subjective economies, were judged not in the same light as men in business or the professions, but by criteria which reflected their role within nineteenth century society, and expectations of female behaviour. Grint (1991) has stated that male representations of what women could and could not do were stronger than female representations. I would further argue that male representations of what women *should* and *should not* do were stronger than female ones. Interestingly, from the literature cited, middle class women appear to have adopted the same criteria as men to judge working class women.

In order to demonstrate the contrast between the living conditions of working class and middle class women, highlighted by the delineation of 'home', this chapter has concentrated on middle class women engaged in philanthropic pursuits, and working class women as clients. This is, however, too simplistic a division to sustain, as both middle and working class women were employed as nurses, in the official as well as the subjective economy. These class divisions will be explored further in chapters 7 and 8. It has also been argued that, as Grint (1991:49) asserts:

> the image of work as separate from, and unrelated to, the home, and the predominance of male breadwinners, is both historically atypical and theoretically vacuous: home and the place of work have always been, and still are, intimately connected by a seamless web of social interdependence.

Notes

[1] In the 19th century, the notion of 'private' was as much concerned with non interference by the state as with ideas about intimacy. We need to use caution in imposing 20th century ideas of the categories 'public' and 'private' in order to avoid misconstruing where the boundaries lay in earlier times.

[2] These ideas were later adopted by the artisan classes, where it was also the responsibility of women to maintain 'respectability'. This is one reason why women were the focus of much philanthropic work, as will be demonstrated in this chapter.

[3] Any analysis, however, needs to move beyond viewing 'production' and 'consumption' as dualistic categories.

[4] 15192 e17 Rathbone W (1890) 'The history and progress of district nursing from 1859 to the present date':10

[5] LMA A/RNY112 Missing Link 1876:58

[6] LMA H1/ST/NCY/7a Nightingale F (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':6

[7] This is probably an underestimate, because of the problems of quantifying women's work, which will be discussed in this chapter, and the fact that census information was collected on what people were, rather than what they did (Rees 1992).

[8] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town' (1865):41

[9] This Act gave the local authority in towns of over 20,000 inhabitants compulsory purchase powers to buy unsanitary dwellings, and replace them with improved housing. As with much Victorian social legislation before 1880, this Act was enabling rather than mandatory, and strongly opposed by the vested interests of landlords.

[10] Shakespeare Birthday Trust 87.3 Annual Report 1872

[11] Bodleian 150 g 19(26) Wilson G (1876) 'Sanitary defects in villages and how to remedy them'

[12] LMA H1/ST/NC/18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London:39

[13] 15192 e17 Rathbone W (1890) 'The history and progress of district nursing from 1859 to the present date':7

[14] LMA H1/ST/NC18/33/5 First Annual Report 1875:25

[15] Henceforth called the Acland Home.

[16] Bodleian Ga Oxon 317 'The story of the Acland home':5-6

[17] This will be argued in chapter 7.

[18] LMA H1/ST/NTS/Y16/1/100a The Cadbury Letters

[19] Bodleian Acland Papers d70

[20] Women were effectively disenfranchised before the 1832 Reform Act, as voting rights were based on ownership of property. The expansion of capital in the nineteenth century meant that it was theoretically possible for women to accumulate enough property to assume voting rights, and the Act closed this opportunity (O'Brien and Penna 1998).

[21] LMA H1/ST/SJ/A19/1 Lady superintendent's report 01.02.1849:3

[22] The specific professional process of District Nursing will be developed in chapter 8.

[23] LMA H1/ST/NC18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London:9

[24] Branca herself, however, tends to gloss over evidence to suggest that the stereotype had at least some merit. For example, she admits the existence of laws which restricted the freedom of women, such as the laws of property, but states that there is little evidence that they were widely used.

[25] Henceforth called the Derbyshire Association.

[26] Derby studies centre A610.73 Annual Report 1884/5

[27] LMA H1/ST/NC18/33/7/1 Annual Report 1890:8-9

[28] ibid. Dr Cheadle gave lectures on hygiene to district nurses in training with the Metropolitan association.

[29] Dingwall (1983) notes the same problem of volunteer lady supervisors for health visitors at the turn of the century.

[30] Women were legally excluded from certain industries, notably mining, and their work in others was proscribed by legal or exclusionary practices (Gamarnikov 1984).

[31] Hakim states (1980:562) that "the focus on the predominant male patterns of economic activity provides only distorted or inadequate coverage of the economic activity of the sizeable female labour force minority." She further argues (1993) that under-reporting of wives' work is a perennial problem, and is more acute in societies and in periods when the ideology of feminine domesticity and wife as dependent are strong. All discussion on women's work in this thesis needs to be interpreted in this light.

[32] LMA H1/ST/NC16/8:14

[33] The magazine of the Ranyard Mission, which was used to inform subscribers of the mission's work and to solicit subscriptions.

[34] LMA A/RNY110 Missing Link 1874:113

[35] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town':46

[36] An exception was Mayhew's 'London labour and London poor', and publications by the Guild of Co-operative Women.

[37] The same ideology of individualism dominated the view of the family, discussed above, as isolated and private, outwith the responsibility of the state.

[38] The responsibility for this was devolved to parish level.

[39] LMA A/RNY121 Missing Link 1885:15

[40] ibid.

[41] Sir Henry Wentworth Acland founded the Schools of Natural Science at Oxford University, where he initiated teaching in biology and was regius professor of medicine.

[42] Bodleian Acland papers d70 Nightingale to H W Acland 4.02.1884

[43] Donzelot (1980) calls this privatised social control, which will be discussed later in this chapter, as will the problematic nature of 'deference'.

[44] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town':19-20

[45] Bodleian 1847.163 'A memoir of Elizabeth Fry, vol.2 edited by two of her daughters' 1847:383

[46] See, for example, correspondence with H W Acland. The Acland papers d 70, Bodleian Library.

[47] LMA A/RNY121 Missing Link 1885:44

[48] The Wellcome Institute SA/QNI/N6/2:2 'District nursing in towns'. A paper read before the Liverpool Women's Conference 1891

[49] Originally called 'The society for the organisation of charitable relief and repressing mendacity'

[50] Derby studies centre A610.73 Annual Report 1869/70

[51] LMA H1/ST/SJ/A32 Pamphlet written by the Reverend Daniel S. Sandforth on his resignation

[52] Henceforth called the Stratford home

[53] Shakespeare Birthday Trust Annual Report 1872:4

[54] Bodleian Acland Papers d70

[55] LMA A/RNY121 Missing Link 1885:179

[56] Guildhall Library 14618 Second annual report 1877:2

[57] LMA H1/ST/NC/V1/69. Charles Langton was secretary of the Liverpool District Nursing Association, and Henry Bonham Carter was Nightingale's nephew, Secretary of the Nightingale Fund, and on the councils of both the Metropolitan Association and the Queen's Institute

[58] LMA H1/ST/NC15/13 a & b Report of the sub-committee of reference and enquiry on district nurses in London:59

[59] Ibid:61

[60] LMA H1/ST/NC18/33/7/1 Annual Report 1881:10

[61] Derbyshire studies centre 610.73 Annual Report 1869-70

[62] LMA H1/ST/NC18/33/7/1 Annual Report 1882:8

[63] ibid.

[64] Bodleian GA Oxon 8^0 560 'Sarah Acland memorial and home for nurses'

CHAPTER 6

Religion and domiciliary nursing

Introduction

Although the history of nursing is associated with a religiosity that has endured to the present, early organisations of district nursing were much more closely aligned to formal religious bodies. This raises the question of why particular sects should become involved in what had been an informal occupation carried out by most women, and why it happened at the time it did. Why was nursing considered an appropriate vehicle for emerging Anglican religious orders (Sisterhoods and Deaconesses), and for evangelical charities? These were the two most important religious sects involved in English district nursing.

A zeal for the conversion of others was the impetus for much of the charitable work, including nursing, conducted by evangelicals during the nineteenth century. Since many conversions occurred during serious illness or following a death in the family, medical missions were often used as the vehicle for intervention. The linking of body and soul, medicine and religion was very common during the nineteenth century (Prochaska 1987), and the influence of evangelicals in the reform of nursing and on the boards of voluntary hospitals has been discussed in chapter 5. Women had an important role in evangelism and "a great deal of emphasis was placed by evangelicals on the power of women to demonstrate by example" (Hall 1979:28). They also benefited from the relative importance of lay people within the movement (Baubérot 1993).

Protestant Sisterhoods, argues Hill (1973: 285-6) "provided important transitional functions in the growth of secular nursing and female occupations generally." They bridged the period between the older type of nursing, based on domestic service, and later professional nursing. They were among the first to identify the need for training, albeit perfunctory when compared with later nineteenth and twentieth century training, and the importance of hospitals in the training of all nurses. The motive of those advocating a hospital training for work both in institutional and domiciliary settings was ostensibly to improve the quality of nursing by the experience of a variety of conditions in short time, and instruction from doctors and experienced nurses. However, as Rafferty (1996) points out medical men objected to the independence and autonomous practice of domiciliary nurses and, as will be shown throughout this thesis, as the century progressed and hospital training lengthened, nurses in private homes and districts came more under the control of hospital authorities and were expected to be deferential to doctors and to carry out medical instruction unquestioningly.

Nightingale toyed with the idea of founding a Sisterhood early in her career, and turned to them when recruiting experienced nurses for the Crimea, although her main attitude towards them seems to have been ambivalence (Hill 1973).

The links between religion and domiciliary nursing will be the focus for this chapter, and these links will be demonstrated by a series of case studies through which a number of analytical points will be made about religion and the organisation of the labour market. I will illustrate the problematic nature of the relationship between work and occupation, as the existence of a pecuniary

relationship between nurses and the organisation was not always present. Freidson's (1978) categorisations of official and subjective labour will be used to analyse the divisions between those whose work was conducted for its exchange value, and those for whom use value was the defining feature. These divisions were further compounded by social class. The idea of vocation, introduced in the last chapter, will be developed as a particular feature of Sisterhoods, but one which became fused with paid labour.

Religion in nineteenth century England

Before exploring the relationship between religion and the development of district nursing it is worth briefly considering the state of religion in the nineteenth century.

Around the middle of the century there was a perceived wisdom that held that the population, especially the poor, was becoming increasingly Godless, and not attending religious services[1]. Nonconformism, however, expanded and Bédarida (1990:87) calls the second half of the century "the golden age of Nonconformism." This expansion was mainly among the middle classes, although Methodism did attract working class followers. The aristocracy, except for a very small number of Roman Catholics, continued to remain Anglican. Catholic communities tended to be concentrated around the remaining old, wealthy Catholic families in places like Lancashire, Durham, Cheshire, Warwick and Staffordshire (Pugh 1994), or large ports.

The 1851 census of religious worship, which is accepted as a reasonably accurate guide to church attendance,[2] showed a great variety in practices. In general terms, the larger the town the lower the proportion of the population

attending church or chapel. Even within cities of similar size there was wide variation, the fastest growing towns in industrial areas having the lowest attendances (Coleman 1980). One reason for this was that the Church of England did not build new churches fast enough to accommodate the populations of expanding industrial cities, but more important were factors of stratification. Skilled artisans and the middle classes were more likely to be church or chapel attenders, so that cities, or areas within cities, where they predominated had higher attendances. Areas where the labouring classes had relatively high church attendance were generally those where influence was exerted by the gentry. There was also a geographical dimension. The Nonconformist churches had large congregations in East Anglia, but were weak in London, and were only strong in other large cities in the regions of the country where they were already well established. This situation improved, especially for Methodism, in the second half of the century, mainly among the artisan and middle classes. This was, perhaps because, as Knight (1995:30) points out "Nonconformity, and Primitive Methodism in particular, gave a voice to the religious conscience of the manual worker, in a way that the more clerically-dominated Anglican and Roman Catholic churches did not."

The only denomination to increase its congregations in the large cities was the Roman Catholic church, due to Irish immigration and a revival from a low ebb at the end of the eighteenth century (Gilley 1995). Converts from the Oxford Movement brought some prestige to Catholicism, despite anti-Irish and anti-Papist prejudice (Bédarida 1990).

Early attempts at providing nurses for the sick poor

Blackwood's Magazine in 1825 (cited by Southey 1829, Stanley 1855) contained an article by the friend of a clergyman who complained of the difficulty in procuring medical attendance for the sick poor of the parish, many of whom lived some distance from the parish surgeon, who, in any case, usually preferred to visit the richer patients.

This situation was contrasted with that in Bruges and Ghent where the Sisters of the Béguine order, many of whom were from wealthy or even noble families, dedicated themselves to this work in hospitals and homes.

It was argued that in England "attendants on the sick, whether professional or menial, are commonly actuated by scientific zeal, by mere natural humanity, or by mercenary motives" (Southey 1829:431). The 'friend' suggested the founding of an order of women like the sisters of charity in Catholic countries selected for "good plain sense, kindness of disposition, indefatigable industry and deep piety, let them receive not a technical and scientific, but a practical medical education" (Southey 1829:435). They could be maintained out of the parish allowance, which was used for the surgeon. He could be resorted to in difficult cases.

A letter two years later in the *London Medical Gazette* (cited by Southey 1829) from a country surgeon[3] also proposed nurses for the sick poor, but reported that efforts to induce the established church to form such an order had met without success.

He referred to a pamphlet signed 'A Country Clergyman', sent to the Bishop of London, recommending that the Sisters should be of a higher order than normal

nurses, so that they would not be thinking of making money, but would be devotees - "religious female physicians" (Southey 1829:447). They would be trained in hospitals and two would be placed in a cottage in country districts, maintained by parish funds and voluntary subscriptions from the wealthy. He thought that Methodists and Quakers were most likely to adopt the plan and that some money going into bible and missionary societies could be used for it. He questioned whether Mrs. Fry could not "divert a little of her zeal from the convicts in Newgate to the sick poor of the country?" (Stanley 1855:37). Southey (1829:318), too, stated that "piety has found its way into your prisons, your hospitals are imploring for it in vain", and although not mentioning her by name alluded to Elizabeth Fry as a suitable woman to organise a school of medicine to care for the sick poor in hospitals and in their homes, along the lines of the Béguines. Fry did, some years later, found a nursing order which will be discussed in this chapter.

Sisterhoods and Deaconesses

The idea of piety arises again with the emergence of Protestant Sisterhoods. Baubérot (1993:202-3) states that "the possibility for middle class Protestants to demonstrate their piety in public and energy in social activities, ... led to a new kind of ministry, that of deaconess. Deaconesses were a product of the social vigour of Protestant Pietism, especially in Germany." Hill (1973) differentiates between Deaconesses, who were more likely to accept the prevailing gender role order, and Sisterhoods which insisted on the right of women to organise their own activities, and whose place within the church's authority structure was extremely tenuous. However, as will be demonstrated

later with regard to St John's House, this division simplifies a complex relationship.

The first house of Deaconesses was founded by Pastor Theodore Fliedner of Kaiserwerth in 1832, following the bankruptcy of a local industry, which left the workforce living in poverty (Jameson 1855). In the following year the Elizabeth Clinic was opened, where Deaconesses cared for the sick. These houses grew out of a belief, alluded to above, that society had a duty to care for the sick and poor. Protestant churches had nothing comparable to the Catholic church, which through its various orders possessed people capable of providing care. Ministries of Deaconesses allowed women to demonstrate total religious commitment, without allowing them ordination (Baubérot 1993). They could be included, but were segregated within the church division of labour. The Kaiserwerth system was to take in novices from other institutions and give them practical experience in caring for the sick and keeping house, which included instruction in medicine by a doctor, in the curing of souls by Fliedner, and care of the sick by his wife. Communities of Deaconesses ran counter to the traditional Protestant view of Christian life, where devotion does not require any special way of life (Baubérot 1993). They were open to the criticism that they were not based on any biblical example. There were also fears that these communities of independent women, some under a Pastor but more often a mother superior, might lead to a depreciation of the value of marriage and a secular life.[4] The glorification of celibacy, a monastic way of life, and exclusive consecration led to the charge of papism, and many women encountered strong family opposition in their attempts to become Deaconesses. For example, at the 1857 annual general meeting of St John's House, the

Master of the Temple admitted to being worried that the Institution "bore something of the Roman mind".[5] Nevertheless, Kaiserwerth was visited by many who were later influential in the development of district nursing in England, notably Elizabeth Fry, Eleanor Ranyard and Florence Nightingale. The first sisterhood in England was founded by Elizabeth Fry in 1840, stimulated by her visit to Kaiserwerth. Because of her other commitments she did not organise it herself, and this work was undertaken by her sister, Mrs. Samuel Gurney, together with some of her daughters, and other ladies.[6]

The Institute of Nursing Sisters, Devonshire Square was founded in order to:

> provide experienced, conscientious and Christian nurses for the sick, and to raise the standard of this useful and important occupation, so as to engage the attention and enlist the services of many who may be desirous of devoting their time to the glory of God, and to the mitigation of human suffering.[7]

The organisation of the Institute can be used to illustrate the fusion of the official and subjective economies, as ideals of piety and vocation will be seen to co-exist with wage earning. The predominance of private patients, and the payment of commission would indicate a market orientation not normally associated with Sisterhoods.

Women were selected carefully and "characters minutely entered into."[8] This did not, however, prevent the committee having to write to the Superintendent in 1842 complaining that Sisters had been seen going into places where spirits were sold, and in 1844 a Sister Dowman was dismissed for drinking alcohol in the home.

They lived in the Devonshire Square home while on probation and then "regularly trained"[9] in one of the public hospitals. The training does, however, appear to have been superficial, as in 1859 Rathbone, when looking for an existing nursing institution to train nurses in order to expand his district nursing scheme in Liverpool, did not consider it adequate. It has to be borne in mind, however, that hospital training of any kind at this time was *ad hoc* and inconsistent, and the training of two months[10] spent at Guy's Hospital would have consisted mainly of observation (Stock 1958).

If the conduct and qualifications of the women were satisfactory they were received as sisters , and they stayed in the home between engagements.

Although the Institute of Nursing Sisters was primarily employed in private families, the application form included the question "Are you willing to attend to the poor as well as the rich?"[11] As trained nurses received commission on their earnings, this may help to explain Summers' finding (1992/3) that they were unwilling to nurse the sick poor.

It was left to the patients to remunerate the society according to their means, as there were no fixed rates. It was hoped that those families where no payment could be made would be helped as promptly as the wealthy. Subscriptions and donations from benefactors meant that all cases that applied and were deemed suitable could be taken on if a sister were available.

Seventy to eighty sisters were employed on a stipend of £20 per annum, which was lower than hospital nurses could expect to receive, and it was often necessary to employ supernumeraries who were efficient and of good character. Nurses were required to bring certificates from all of their cases

stating their efficiency and conduct. With rare exceptions these were all stated to be satisfactory.[12]

While in the home between cases, the sisters devoted part of their time in "visiting and nursing the sick poor in the densely peopled and wretched districts in its neighbourhood"[13] (Bishopsgate) but having found this work difficult to carry out because of the claims for private nursing, one nurse was appointed to remain in the home and be devoted to the care of the poor.

The institution wished to employ more such women:

> possessed of the various qualifications requisite for rightly and efficiently carrying on this work, and especially of such a spirit of piety as shall dispose them to desire the situation rather for the active exercise of Christian charity to which it devotes them, than for any other advantage which they may obtain.[14]

Nursing of the sick poor does not feature largely in house committee minutes, which were mainly concerned with the conduct of the nurses in private families, and applications to the Institution. There was a 'poor journal' which was read out at a few meetings in 1853, but no comment was made on the contents. On September 2nd 1853 it was decided to engage a poor woman to assist with the sick poor by cleaning their homes.[15]

From around the end of 1856, the minutes began to list cases which had been accepted on reduced rates, or gratuitously. An example from June 4th 1858 announces that "Mrs Franks to have nurse for one month at 10 shillings a week, Charles Smith to have a nurse for six weeks gratuitously, though he has offered 5 shillings a week."[16]

The annual report of 1859 commented that "the services of several Sisters are now also granted by the committee, to devote the whole of their time to visiting the sick poor, under the direction of the clergy of the parish to which they are appointed."[17]

Florence Lees 1875 report into district nursing in London stated that trained nurses, by which she would have meant at least one year's hospital training, and who by this time were being admitted to the Institute, nursed only private patients in families. She quoted a clergyman in Bethnal Green whose parish had one of the district nurses "She has not been regularly trained, but learnt much from experience."[18] He added that he felt that he knew more about nursing than she did.

The Institute of Nursing Sisters illustrates the mixture of vocation and wage earning described in the last chapter as fusing the official and subjective economies. The idea of piety and earning an income does not appear to have been perceived as incompatible here, the payment of commission suggesting a market relationship not normally associated with Sisterhoods. As will be seen, this contrasts strongly with other Protestant Institutions which conformed more closely to middle class female philanthropy. In these a hierarchy existed in which official labour was considered inferior to subjective labour.

The North London Deaconesses Institute, founded in 1861, was an organisation of district nurses modelled on Kaiserwerth. It was formed for the organisation of women's work in the church, and was under the sanction of the Bishop of London. He recognised the Sisters and, after a satisfactory one year's probation, allowed them to assume the title 'Deaconess'. The Institute

reflects the division between official and subjective labour, with those involved in subjective labour being considered morally superior to waged nurses.

The nurses were trained in the management of schools, care of the sick, and received such instruction to enable them to "superintend that portion of parish work which is, or can be, intrusted (*sic*) to a woman."[19]

Its purpose was "to undertake the visitation of parishes under the superintendence of the clergy, nursing the sick, the charge of schools and other works of Christian usefulness"[20], and, at least initially, the work of the school seemed more developed.

A small three bedded ward, intended to act as a nursing school was opened in the home. Patients of a higher social position who were in reduced circumstances due to disease could be admitted, and those in the end stage of consumption or similar were considered the most eligible. Chronic incurables, who would use the bed for a long time and prevent other admissions were inadmissible. Payment was 7 shillings per week.

Sisters served the Institute for three years, which was renewable, but were not bound by any vows. Any Sister in a position to do so was expected to contribute a sizeable portion of her income to it, and if this was more than was required to keep her it was used to subsidise poorer Sisters. The Institute did not, however, take over management of their personal property. Neither Sisters nor Deaconesses received a salary. By displaying spirituality, being unpaid, and not carrying out domestic work, middle class women were able to maintain their respectability, and engage in work outside of the home (Helmstadter 1996).

Women "of a lower social order"[21] were admitted as subordinate sisters, performing the work of nurses and domestic servants, and lady volunteers helped with the work, and made donations.

This seems to reflect the idea advanced by 'A Country Clergyman' cited above, and by Stanley (1855:49), who stated that nurses who work for gain will be of the lowest orders because the work is hard, the "duties often disgusting" and the remuneration poor. Women of a higher social class would do the work from a higher motive. "To the true Christian the vocation of nursing appears in a very different light. The responsibilities and difficulties do not seem less, but these are compensated for by the privilege both for time and eternity".[22] This idea of middle class women working from pious motives conformed to the dominant image of them as virtuous and chaste, unlike their working class counterparts, and as will become apparent, this was a feature of district nursing associations beyond the Sisterhoods.

The North London Deaconesses Institute demonstrates the inadequacy of a dualism of professional and amateur when analysing district nursing as an occupation. The subordinate sisters constituted part of the official economy, carrying out work for its exchange value in the form of money. The work of the Deaconesses and Sisters, as part of the subjective labour force, was primarily of use value, but there was a symbolic reward in that it offered wealthy women an acceptable alternative to marriage, and some measure of independence. Altruism and self interest can be seen to coincide. Demarcation of the work between nursing and domestic duties was based on the ability to contribute to the Institute, which also determined the hierarchical division of labour.

Reaction to Sisterhoods was mixed. In 1865 Rathbone wrote that they were "regarded with deep and unreasoning suspicion by the great majority of Protestant Englishmen."[23]

However, Jameson (1855:1) advocated Sisters of Charity:

> not merely as the designation of a particular order of women, belonging to a particular church, but also in a far more comprehensive sense, in indicating the vocation of a large number of women in every country, class and creed.

As she did not approve of nunneries, whether Catholic or Protestant, her ideas for Sisterhoods would not have adopted their organisation.

Dr. Cumming (quoted by Stanley 1855:48) did wish to see denominational Sisterhoods:

> During the period of seven years, twenty six nunneries and convents have been opened in England; and I cannot pass through Southampton-row without meeting two and two of the Sisters of Charity, each with a basket, one containing Romish spiritual, the other containing English corporal, nutriment; and both labouring to make proselytes of poor to the Roman Catholic religion. I only wish we had Sisters of Charity, not of the Popish or Puseyite breed, but of the right Bible and Protestant stamp, attached to our churches in order that we may have a full apostolic complement.

Both the Institute of Nursing Sisters and the North London Deaconesses primarily provided nurses for private families, and undertook gratuitous district nursing only when nurses were free. The Kaiserwerth model was adopted, therefore, only in so far as the organisation of the Institute was concerned, not

in the philosophy, although the rhetoric of piety and charity would suggest that this was the case. Fliedner later told Agnes Jones that:

> he was so disappointed to find Mrs. Fry's work, about which they had consulted together, so much a limited one, as he says the nurses' sphere is so limited in comparison to what it might be, and also there is no attempt made to raise them by mental culture.[24]

Other Sisterhoods, like the Society of Sisters of Mercy founded in 1847, had broader aims than just nursing the sick poor. Its founder Miss Sellon took her "little fortune" (Goodman 1862:2) to relieve the misery of the poor in maritime towns. Houses were obtained in different parts of the country, each devoted to a different order. The Abbey at Plymouth was mainly devoted to the 'Order of the Holy Communion', which ran an orphanage, a ragged school, an industrial school, and sublet rooms in houses to the poor who would abide by certain rules of behaviour. The outer orders of Sisters would help residents with reading, writing and arithmetic, and also subjects they requested such as drawing and French, but the inner orders were mainly contemplative. The society did not train nurses, but some Sisters had nursing experience, and they worked in the hospital run by the Order, and visited the sick poor at home, mainly during cholera epidemics. Many of the patients were Irish Roman Catholics, but there was no interference in religious beliefs (Goodman 1862). They provided food and comforts as well as nursing, and stayed overnight with patients too ill to be moved to the cholera hospital. St. Saviour's in London housed the Order of the Holy Ghost, which differed from the other orders in that women lived in their own homes and conformed to certain rules, but

intermittently resided in the house where they devoted themselves to visiting the sick poor.

More than either the Institute of Nursing Sisters or the North London Deaconesses, the Society of the Sisters of Mercy reflected the ideals of the continental Protestant Sisterhoods. It worked exclusively with the poor, and the Sisters lived a monastic way of life, based on prayer and contemplation, in a wholly female community. The Sisters appear to have endorsed the idea of vocation as a subjugation of self, carrying out work of use value, with no regard to exchange.

St John's House

Although The Institute of Nursing Sisters was the first in the field, St John's House was the first to attempt to organise nursing on definite church lines.[25] It was also the first organisation to attempt to provide trained nurses for all classes of society, in hospitals and in the community. The organisation of labour in St. John's House is characterised by not only hierarchical divisions between official and subjective labour, but also by a gender division of labour based on task distribution. Patriarchal power relationships were not just uncritically accepted, but positively endorsed. Although other Sisterhoods had mostly male organising committees, St John's House deliberately structured its organisation with a male warden at its head, with all females, whatever their position, subservient.

In 1847 Drs Todd and Few wanted to establish an improved system of nursing, by providing professional training together with moral and religious discipline. They argued:

> that great difficulty is at present experienced in finding well qualified nurses for hospitals, families and the poor, and that great benefit would be conferred on society, and on the profession of nurses in particular by training them to regard their work as a religious one, and that it may also be reasonably expected that many women of the middle and upper classes could cheerfully devote a portion of their time to promote the welfare of society and the Divine Glory by ministering to the wants and relieving the suffering of those who are afflicted by sickness.[26]

The aim, then, was to form an Institution for educating and maintaining a community of females who would receive instruction and training to fit them to act as nurses, and that it should be "a *sisterhood of ladies, united by a religious tie* - without vows - in connection with the Church of England, aided by a council of men, to conduct their business affairs with the outer world" (Few 1884, original emphasis). Presumably in order to avoid any charge of Papism it was made quite explicit that there would be "no vows of poverty, monastic obedience or celibacy, no cloistered seclusion, no tyranny exercised over the will or the conscience, but a full, free and willing devotion to the great cause of Christian charity."[27] Drs Todd and Few did not justify why they thought that nursing should be a religious occupation, when they were not advocating that doctors or dressers should be organised along these lines.

In October 1848, a letter was sent to Archdeacons and other clergy all over England asking them to become corresponding members of the Institution, and pointing out that their onerous duty of visiting the sick could be alleviated:

> by training a class of women in sound and enlightened attachment to the Church of England who would act under their pastoral direction in attending the sick in their parishes, and in whose

> professional skill and religious principles they might safely repose confidence.[28]

It was proposed that St John's House should be under the immediate control of a clergyman of the Church of England and Ireland, with the title of Warden (later changed to Chaplain). Miss Frere, the first Lady Superintendent, concurred with the idea of a male head, as she felt that it would induce ladies qualified to undertake the work, who would not accept the responsibility "without the presence and authority of a master, who would be in reality as well as in name the Head of the Establishment."[29] It would give the ladies authority over "subordinate classes of inmate."[30] The duties of the lady superintendent were domestic arrangements, admission of inmates and their appointment to various situations and duties.

The inmates were divided into three classes:

- Probationers, literate young women who would be trained in a public hospital for two years and if satisfactory be accepted as nurses. It was some years before a two year training became a reality.
- Nurses, who may or may not come from the ranks of probationers, and who would nurse the sick in hospitals and private houses, and when not engaged would instruct the probationers.
- Sisters, "to whom, especially, the Institution will look for the maintenance of a high moral and religious tone in the common family of the establishment."[31] They were also to visit the sick in their homes and in hospital, and to take part in the religious instruction of the probationers.

A hierarchy based on gender and social class was apparent here, which determined the distribution of tasks. Sisters, who would be women of

independent means, were expected to raise the standard of hospital and private duty nurses by setting an example of religious piety and dutiful obedience to the lower class paid nurses of the Institution, and by reporting any wrong doing. The Sisters and Lady Superintendent in turn accepted that the Master should have overall authority. Again we see a gender division of labour based around task specification, with unquestioning acceptance of patriarchal power relations.

This structure is analogous to the Victorian household, as Gamarnikov (1978) described the situation in hospitals. The Sisters would be used to instructing household servants, the authority being delegated from the male head - in this case the Master. It refutes Hill's assertion of the independent female Sisterhood.

An annual payment was required from probationers for board and uniform, but nurses were to be remunerated. The Sisters, if resident in the Institution,[32] contributed an annual sum. In the first instance all applicants for the post of Lady Superintendent wanted payment, whereas the Council required someone who would "devote herself to the work on simply religious and charitable grounds unembarrassed by pecuniary considerations."[33]

Later Miss Frere argued for salaries to be paid in order to attract "the best sort of nurses at present to connect themselves with our institution."[34]

As with the North London Deaconesses, a demarcation between the official and subjective economy is demonstrated, but here this is complicated by the salary being paid to the Lady Superintendent. The link between piety and volunteer labour, and the assumption of its superiority over paid labour is overturned with the argument that a salary was necessary to attract the best

sort of nurse. If we look at where this link between piety, volunteer labour and nursing originated, it can be seen to be from male doctors and clergy in the 1820s, and the male committees of the Sisterhoods. It was a female, Miss Frere, who linked a salary with attracting the best nurses, and this may reflect my extension of Grint's argument in chapter 5, that male representations of what women should and should not do were stronger than female ones. In this case middle and upper class women were not expected to become part of the official economy, but could engage in a vocation.

The training in the first instance was three months in the wards of the Middlesex and King's College Hospitals, although a shorter training was given to those deemed "partially trained" or experienced in nursing. This later increased to six, nine or twelve months.

The Institution started with three Sisters and six nurses, most of whom nursed private patients. But on 26th May 1849, the Lady Superintendent reported "We have been enabled also to give considerable help gratuitously to many sick poor persons in our district, in which duty all nurses have taken part with great willingness and kindness."[35]

This contrasts with Summers (1991:141), who states that nurses from the Institute of Nursing Sisters found working conditions in the homes of the poor to be disagreeable, and that "some nurses took no pains to hide feelings of resentment or even contempt in their management of 'poor cases'." St. John's nurses did, however, acknowledge that the extreme poverty and wretchedness encountered made the nursing arduous.

The Lady Superintendent's reports to the Council include references from private homes as to the conduct of nurses, and the work done amongst the

poor, which is mainly by nurses in between private cases or hospital work. An example from June 1849 states

> We have highly satisfactory reports of our nurses Mrs Dicks and Mrs Busby .... of Mrs Jay she is now attending a gentleman at Brompton the Lady Superintendent regrets to say she has not had such a pleasing account. Mr Partridge called upon the Lady Superintendent a week since to say that he considered her .... a careless, inefficient person, very inattentive to the orders given and very dilatory in obeying them and very often neglecting them entirely and not keeping her patient in that neat comfortable state which is so requisite for an invalid.[36]

Mrs Jay was later dismissed, as were a number of other nurses given unsatisfactory reports by private patients.[37]

In 1856 St John's took over the nursing at King's College Hospital (KCH), thereby extending the influence of the Sisters into institutional settings. The Sisterhoods had long been critical of the standards of institutional care, and in 1842 some nurses from the Institute of Nursing Sisters threatened to leave the London Hospital because it was so dirty. Summers (1991) states that nursing reform was the result not of changes originating within hospitals, but of the Sisterhoods wishing to deliver the same standard of care within hospitals as was expected within the homes of the rich. Not all private nursing was of such a high standard, however, as the superintendent of St. John's House pointed out in a letter to Rathbone in 1865 that much nursing in private families was unsatisfactory, and more difficult to improve than hospital nursing.[38] This was acknowledged at the time, as in 1875 Florence Lees wrote that St John's house and sisterhood "has done so much for raising the standard of nursing".[39] The

influence worked in both directions, however by, as Rafferty has argued, bringing domiciliary nurses under the control of hospital doctors.

The move into KCH, and later into other hospitals (for example Charing Cross in 1866) meant that fewer nurses were available for private and district work, although it did provide more financial stability to the Institution. Demand always outstripped supply, and private patients took precedence over district work. In 1857, a year after St John's took over nursing at KCH, the annual report of the council stated "Nor have the poor in Westminster been neglected, though they have not been attended to the same extent as in former years."[40] District work did, however, continue to be undertaken not just in London, but in other areas of the country, especially during epidemics. In 1871 two nurses were sent to nurse scarlet fever in country parishes and two others to a typhoid fever epidemic in a colliery district. In November of that year, while nursing a fever epidemic in Chesham, two out of six nurses died.

By the 1880s hospitals were terminating their agreements with St John's, and providing their own training for nurses, and it was decided that St John's nurses should undertake district nursing in parishes where no other such nursing was provided. Although private patients were subsequently nursed at reduced rates, where circumstances warranted it, by 1893 gratuitous nursing of the poor had been severely curtailed due to financial constraints.

By 1900 St John's House was training very few nurses, but employing trained nurses for private work. In order to attract them to the Institution profits on earnings began to be distributed as a bonus, which may well have affected their willingness to undertake district work, and little was done after this date. The idea that vocation and subjective labour were the only means for middle class

women to enter the workforce was, by this time, no longer dominant. The commercialism of the official economy was accepted, but servitude and obedience remained features of women's occupations. Nursing may be regarded here as a fusion of vocation and official labour.

The English Sisterhoods appear to have been more male dominated than those on the continent, as described by Baubérot. Committees were almost entirely male, and a Master was almost invariably in charge over the Lady Superintendent. The exception to this was Miss Sellon's Sisterhood, which was not exclusively a nursing order, neither did it undertake paid work. Sisterhoods may have offered an alternative to marriage and control by male family members, but the strict regulations would suggest the exchange of one form of patriarchal control for another. As with middle class philanthropy, the gender division of labour was based around task distribution, with male committees deciding policy and managing the organisation and women carrying out the nursing tasks. This division has been shown to cause tensions over the payment of a superintendent at St. John's, as male ideas of female vocation and piety were at odds with the idea of paid work.

This strict control and emphasis on obedience accords with Rafferty's (1996) assertion that domiciliary nurses were regarded by doctors as too autonomous, and Sisterhoods were part of the strategy of bringing them under medical control. This may well explain the desire of Drs Few and Todd that nursing be linked to a religious establishment. St John's House was the first to attempt any form of nurse training beyond the rudimentary, but the rationale is more complex than simply one of control. Summers (1991) argues that it was in the

homes of the rich that demands for higher standards emerged, and this is certainly borne out by the reports of the Sisterhoods, as they responded to these demands. The two arguments are not, however, mutually exclusive, and the demand for high standards could have provided the opportunity for male intervention in nursing work.

The hierarchy apparent in both the North London Deaconesses and St John's House, based on the perceived superiority of the combination of piety and volunteer labour over paid labour, is analogous to the differentiation between gentlemen and players (Horobin 1983). Until recently to be paid for competing in a sport was held to be socially inferior to competing as an amateur, the need for market exchange conferring a lower social status. This will also be seen to be the case with paid nurses and lady superintendents, but becomes problematic for district nurses wishing to create a profession at the end of the century.[41]

There is some confusion over the involvement of KCH in the foundation of St John's House. Two doctors, Few and Todd, were instrumental in establishing St John's, but Few (1884) asserts that there was no involvement with KCH until the Institution took over the nursing there in 1856. Both men did, however, express concern over the nursing at KCH earlier than this. Yet an anonymous history of St John's states that a Dr. Bowman from KCH was instrumental in arranging the public meeting which resulted in the setting up of St John's following a letter from him to other medical men on the lack of good nurses.[42] If this version of events is true it would support Rafferty's assertion. A strong incentive to establish Sisterhoods, however, seems to have been to aid the clergy in their role with the poor in the growing cities. The letter sent from

the Council to English Archdeacons and clergy in October 1848 (cited above) points out that:

> a class of intelligent and trustworthy nurses, duly qualified by religious and medical training to attend upon the sick .... [can] alleviate in some degree the onerous burden of visiting the sick, which usually engages so much of the time, and presses so heavily on the strength of the parochial clergy.[43]

Many clergymen did, in fact, pay the Institutions for district nurses to be employed in their parishes.

So in the development of Sisterhoods, the interests of both medical men and the clergy would seem to coincide. It may, therefore, be the case that in order to meet the interests of these two groups of men *nursing* Sisterhoods were less autonomous than those described by Hill.

If middle class philanthropy, in an age of capitalist expansion, provided the context in which district nursing could emerge as an occupation, the re-emergence of Protestant Sisterhoods provided the organisational catalyst. This was shaped by patriarchal power relationships, particularly the demarcatory politics of medical men, yet it opened up the opportunity for a claim of jurisdiction over the care of the sick in their homes, and later in hospitals. Protestant Sisterhoods did not provide the only link between religion and domiciliary nursing. Evangelicals had been developing district visiting as a way of proselytising the Christian message to the poor since around the 1820s, and many would give some form of care to the sick at the same time. One evangelical mission which went beyond this to found a separate nursing branch will now be discussed.

The London Bible and Domestic Female Mission (The Ranyard Mission)

The organisation of labour by the Ranyard Mission, like the Sisterhoods, utilised a hierarchy based on a division between official and subjective labour, but in this instance it determined who carried out nursing work, and who acted as supervisors. The Mission also clearly demarcated between its work and the work of Roman Catholic Sisters of Mercy. In this section I will analyse these divisions, but first I will briefly examine the evangelical movement of the nineteenth century.

The values and morality of the middle classes, which were so dominant in the middle part of the nineteenth century, were those espoused by the evangelical movement. This began in the eighteenth century, but it was between 1800 and 1860 that it was most influential. It had emerged as a reaction from within the Church of England against what was perceived as immorality, hedonism and a style of religion that was intellectual and rational (Bradley 1976). The Clapham Sect, whose members were regarded as the leaders of the movement, was highly influential politically and socially during the first half of the nineteenth century. It espoused the anti-slavery campaign, and reform of manners and morals (Hall 1979). Its emphasis on family life and respectability became the blueprint for the middle class Victorian household. For evangelicals religion was emotional and anti-intellectual, epitomised by the doctrine of conversion (Bradley 1976). Humanity was perceived as corrupt and sinful, and salvation could only be had by total repentance and acceptance of Christ's atonement. The reward was a place in heaven and a better life after death than before it.

The lives of the poor were precarious, and chronic or fatal illnesses for which medical science could offer no cure and little relief from suffering were common. The only hope that could be given to people was a better life after death, but this was conditional on accepting Christ. Religion made sense, in that it offered an explanation for the conditions of life, and consolation in a better afterlife (Prochaska 1987).

Existing social structures and the organisation of society were not challenged, but justified as the will of God, which could not be questioned (Hart 1977).

The poor were generally thought to be responsible for their conditions and their poverty. Idleness, alcohol and depravity all contributed, and the solutions were therefore in the hands of the poor themselves, in such virtues as thrift, cleanliness and hard work. Most of the evangelical charities had the dual aim of providing initial help in order that the poor could become self sufficient, and providing religious instruction, and education on the consequences of vice. The balance of these aims differed between organisations (Rack 1973), as did the extent to which charities differentiated between the deserving and the non-deserving poor.

Concurrent with the rise of evangelism was an influx of labour into the expanding cities, engendering among the upper and middle classes a heightened sense of class division, and the opportunity for mass disruption and social unrest (Bédarida 1990). Thoughts of the French Revolution inciting similar revolutionary tactics in Britain produced fears about social control among an unstable and geographically mobile population. There was awareness of a link between political and religious radicalism, that working class political radicals

were often religious radicals, so attempts to deal with one would alleviate the other (Rack, 1973).

Ellen Ranyard was an evangelical Christian who had from an early age visited the poor in South London on behalf of the Bible Society.

In 1857, when living in Bloomsbury, Ranyard went for a walk in the Seven Dials district, an area where as many as four families shared one room (one corner each), and sanitation consisted of one water pump in the courts of the housing blocks. She was concerned that if people's physical needs were so great, then their spiritual need must be equally unmet. It has been noted that the linking of body and soul, medicine and religion was very common during the nineteenth century, particularly by evangelicals. As Prochaska (1987:336) commented, "This unity of interest flowed from a central doctrine of Christianity: that sin led to suffering." Ranyard saw the main need of the poor as the word of God (Platt 1939), yet there were many ministers and city missioners working in these areas. She thought that if anything was going to help the poor, it had to be achieved through the wives and mothers, it was they who could turn slum dwellings into Christian homes. So Ranyard's mission was to be a women's mission to women. No middle class woman could have worked in the courts, or gone into the homes of the poor and been accepted, nor was it thought that they should go to such places, but a working woman from the same class, or 'native agent'[44] as Ranyard described her, one who had been transformed through Christianity could work with the women of Seven Dials. Each biblewoman was to be supplied with bibles which she would sell to the poor by subscription. She would be supervised in this work by a lady

superintendent, to whom she would report weekly, and receive the supply of bibles. These biblewomen Ranyard thought of as the 'Missing Link' between the rich and the poor.

By 1868 it was felt that the work was becoming more of a mission to the sick, as many biblewomen were sitting up at night with the sick and offering comfort. They would beg or borrow sheets, arrowroot or jelly for them, which went against the ethos of self help, which held that "the Biblewoman should not be looked for merely as minister of temporal good when her errand is to be a soul seeker."[45] The nursing mission which was subsequently started was described by Ranyard as the 'Second Missing Link' .

As with the Sisterhoods, the Ranyard Mission demonstrates a hierarchical division between official and volunteer labour, but whereas with the Sisterhoods there was a demarcation of tasks in which more menial domestic tasks were the province of the official labour force, here the volunteer labour force was not involved with the actual tasks of the organisation at all. There was complete segregation of the official and subjective economies, with subjective labour being used in a supervisory capacity. This will be explored in the next chapter, as the tension between paid and voluntary supervisors was a crucial factor in professionalising strategies. The Ranyard Mission also differed from the Sisterhoods in seemingly not accepting existing patriarchal power relationships within the gender division of labour. All aspects of caring, including organisation and policy making were seen to rest in the female domain.[46]

The sick room offered the first entrance to many homes, and more conversions (or "souls to the feet of Jesus"[47]) came from the ranks of the sick poor than

from any other source. As the biblewomen went around their districts, it was easy for them to hear about and report sickness to the nurses. The nurses, while ministering to the sick would be "watching everywhere for the fitting opportunity to drop a word that shall turn the eye of the sufferer upwards to the great physician".[48] When a patient was taken off the bible nurse's books a biblewoman would visit in order to induce her to subscribe to the bible and to attend a mother's meeting.

One lady volunteer commented "I am delighted to find how humbly and perseveringly they go to their various duties".[49] The nurse stays long enough to do what they require and "drop the words of Christian love and comfort, and direct the sister or daughter in the needed measures for relief, and then passes on to other urgent cases, returning at stated periods".[50] Nurses carry to every soul "waiting for the right moment to deliver it THE MESSAGE FROM GOD".[51] They do not preach but at the right moment quietly teach "what it most concerns a sick or dying person to know"

It was accepted that the nurse would not have time to read prayers in her work, so it was expected that they show their Christianity in two ways. First, she must live it and secondly "while she rates the body high, she must rate the soul higher" and "drop a text, breath a prayer"[52] while she went about her work.

<u>Case studies from the Ranyard Mission</u>

These were written in order to attract funds and also to inform contributors about the success of the mission's main aims of spreading the word of God to the poor, and helping the poor to help themselves. Cases of successful conversions were the ones most commonly described.

John H. had had contraction of the leg for 20 months. He and his wife and children lived on 4 shillings per week parish relief. An unnamed biblewoman nurse described them as "very poor but cleanly. .... They are not yet believers but inquirers after the truth, and willing to welcome the reading of the Word (sic) and prayer".[53] Money was collected in order to help the man improve (?retrain) as a shoemaker, as it was unlikely the leg would recover.

The medical lady in her report describes a man who is crippled and his wife who is ill following childbirth

> She spoke most touchingly of the love and care of God: how since she had been able to come to Him as her father, He had opened her way and either provided a supply for her or allowed her to live with very little food.[54]

A man with consumption was visited by a biblewoman. He had once been what was described as 'comfortable', but had become poor due to illness. She read the scriptures to him "till the full light of the glorious gospel shone in his heart".[55] For 6 weeks before he died he was nursed by a biblewoman nurse who said "his death was triumphant". He said just before death "If I had the strength I could sing for joy, for soon I shall be with my saviour".[56]

The difference in the deaths of two women is described in a nurse's journal. In the first case the nurse arrived too late to redeem her and she died shrieking and thinking she was going to hell. In the second, a woman in the flat below who had heard this and did not want such a death, was visited by the biblewoman and the nurse, and by the time she died knew that Jesus had forgiven her sins, and so died in peace. This was an example of what it was claimed the biblewoman and nurse working together could achieve.

Children, too were used to demonstrate the work of the mission. A nurse reports her visits to a ten year old boy with a diseased spine, and four large wounds on his back

> I have learned many a lesson from this sweet Christian child. I used to carry him an orange or a few grapes sometimes, for this was almost all he could take, and say - 'Well, Freddy dear, how are you this morning?' 'I don't think I'm any better Nurse, but I hope I shall soon go to Jesus'. He seemed to be thinking constantly of Jesus and Heaven and longing to be there.[57]

What is not reported is what nurses told patients about 'Jesus' and 'Heaven' that made them almost eager to die.

The successful stories were given much more prominence than cases where the person does not espouse Christianity. One nurse's cases were described in detail, but her lack of success in conversion glossed over "This nurse has many other cases of a different character - some in gross darkness, and others quite indifferent to their immortal state".[58] These cases were not reported individually.

A Lady Superintendent reported on a man in the last stages of consumption "I did not know he was a confirmed infidel".[59] He refused to let her pray for him, but was grateful for the nursing.

<u>Rivalry with Roman Catholic Missions</u>

Although the vast majority of Sisterhoods in England were Protestant there were some Roman Catholic institutions who worked mainly, but not exclusively in Catholic parishes - for example, the Soeurs de Bon Secours, an untrained order working in Bayswater; the Soeurs de Bon Secours, Haverstock

Hill, which was the only association to visit the sick at home; and the Sisters of St Vincent de Paul, who were trained at Lisle St. Hospital, and worked at the French Hospital and dispensary.

The second Anglican evangelical revival, which began around 1858 (Bradley 1976), was more fanatically anti-Catholic than had previously been the case. Britain's place in the world was perceived by the middle classes as bound up with the Protestant ethic of industry, sobriety and thrift (Gilley 1995). He adds

> Moreover the mass of Englishmen defined these national virtues as the antithesis of Roman Catholic poverty and dirt, summed up as "popery and wooden shoes". Protestantism was patriotism, and popery was the religion of England's enemies, France and Spain, and of the despised sister kingdom of Ireland." (Gilley 1995:33)

Although the Ranyard Mission was non-sectarian, it was Protestant, and totally antagonistic towards the Catholic worship of the Virgin Mary. An exploration of this antagonism helps to explain the religious and sectarian drive to capture the market for the sick poor.

From very early days there appears to have been some rivalry between the Catholic Sisterhoods and biblewomen, based mainly on the doctrine of Mariology, which includes the role of the Virgin as intercessor (Warner 1990). Mary, mother of Jesus, is the advocate who pleads with God for the reprieve of the suffering of humanity after death, and an afterlife in heaven.

This affected how all women were perceived by the Catholic church. After the restoration of the Roman Catholic church in France in 1801, the Catholic feminine model was characterised by the "noble bravery" of Marie Antoinette, the Duchess of Angoulême and the energy of Maria Caroline of Berry. They

epitomised the proof of women's superior character, thus priest and feminist were "united in their ennoblement of women." (de Giorgio 1993:66) The feminine soul, different from, and complementary to, the masculine, became for the church of the restoration a reservoir of civilising resources and of conversion possibilities, based on the piety of the Virgin Mary.

"The feminine Catholic model was exclusively that of the wife and mother. The church demanded from the wife submission and the spirit of self denial" (de Giorgio 1993:172). For Protestants, too, the feminine was the civilising influence which, as has been noted, was Ranyard's rationale for working with women.

The model was most evident in Italy, but in the USA and England a high degree of emancipation emerged, and new self supporting religious orders were founded.

Ranyard nurses on their rounds often met the English representatives of the French Sisters of Mercy, who had more in the way of food, clothing and money to give to the poor, as opposed to mission nurses who were expected to adhere to the policy of self help. "Many of them are ladies whose soft and gentle manner, added to the earnestness of their belief in a false God, make them dangerous visitors to a sick room".[60] The sick admire their kindness and at last come to listen to the teaching "where at first he would have dreaded the idea of being perverted".[61] There were more Catholic than Protestant nurses for the sick poor, and Ranyard asks "Ought we allow this still to be the case?".[62]

On one occasion a biblewoman was refused entry to a house because the Sister who was treating a child refused to return as long as the biblewoman was allowed in.

The January 1870 edition of the Missing Link carried an editorial of anti Catholic rhetoric titled 'How does Rome break the ten commandments?' by Ranyard, who had just returned from a visit to Rome. However, later that year it was asserting that "those who know our publication best will acquit us of any desire for proselytism".[63]

At the request of a biblewoman a nurse visited a Roman Catholic who was ill with consumption.

> While so many are perverted by the wiles and blandishments of Rome among the higher classes, it may do good to tell of this one humble soul, who first heard of the only way of salvation, and accepted it, from the bible woman and the bible woman nurse. The nurse wrote "When I first saw him I pointed out to him that the priest could not save him. 'Ah, but' he said 'the virgin can intercede for us'. I told him that Jesus shed his precious blood to save us from our sins, and lives to intercede for us and we need no other intercession. I left a little tract with him entitled 'Lord, show me my own heart' and said as I left him 'Now I want you to add that prayer to yours every day'. He promised he would.[64]

He began to accept what the nurse told him and eventually asked his landlord to prevent the priest from coming in to see him. The priest kept returning (and started bringing a big black dog, which guarded the door) to make the man take confession, but the patient always told him that he would confess only to God, and not to man.

In another case a Catholic woman, who was being treated for leg ulcers, believed that Jesus had given Mary the power to forgive sins. The nurse told her that Mary had no more power than she, and that Jesus is the only mediator between God and man. The nurse took the woman food and beef tea when she

had nothing and the leg improved. The biblewoman visited and the woman started to attend mothers' meetings. The nurse believed that she was "resting only on Jesus".[65] This phrase 'resting only on Jesus' is often used to describe Roman Catholics who renounced the glorification of the Virgin Mary.

The organisation of the Ranyard Mission has illustrated a social class hierarchy, based not on a differentiation of tasks, like the Sisterhoods, but one where subjective labour was used to supervise the work of labour in the official economy. The presence of subjective labour helped to justify the use of a 'native agent' by the Mission, as the work of working class women was controlled by middle class women. The Mission was also keen to demarcate between its work of helping the poor to help themselves, which reflected the evangelical doctrine of self help and thrift, and the Roman Catholic Sisters' use of material relief.

Challenges to the role of organised religion in district nursing

There was not universal agreement that organised religion had a place in district nursing. In 1860 a pamphlet[66] was sent from 'a physician' to Florence Nightingale, arguing some of the ideas about district nursing that she was later to espouse, although she had not previously shown any interest in the subject. The physician advocated a system of trained nurses for the poor, but argued against this being organised by religions, as there was too much bitterness between sects.

In Derbyshire disagreement on the role that religions or sects should play caused a rift within the organising committee. In 1865 it was proposed, at a

meeting chaired by the Bishop of Lichfield, to form an association for the supply of trained nurses for hospitals, parochial districts and private families. Each archdeaconry should form a standing committee of laity and clergy to find suitable women to train, and to raise funds. The nurses when trained would work in parochial districts.

A separate organisation, the Derby and Derbyshire Nursing and Sanitary Association, was subsequently set up because some present at the meeting, including clergy, were unhappy about the ecumenical nature of the diocesan association. They felt that those who were not members of the Church of England should be allowed to co-operate in the work. It was argued that nurses should not be used "for the propagation of distinctive religious opinions."[67] This disagreement could not be resolved, and in a letter on March 21st 1865 the Bishop regretted that there would be two associations in Derbyshire, but agreed to become a patron.

Other examples of associations discouraging any form of proselytising can be found in the archives. It has already been noted, for example, that Miss Sellon's nurses did not interfere with their Catholic patients' religious views.

The Queen' Institute made it a condition of affiliation that associations should not interfere in any way with the religious opinions of patients or members of their families. As the President, Peile, stated in 1892

> We have nothing to do with religious work. We train nurses to look after the sick and suffering body, and we never allow the nurses [to] combine the mission woman and the nurse .... If this were not insisted upon, the nurse would often be regarded as a proselytiser, and the nursing work in general would be suspected of having some other aim.[68]

In 1891 the Ranyard Mission was refused affiliation to the Queen's Institute because of the length of nurses' training and because of the religious element within its institution. It retorted "It is impossible for us to depart from these principles, or to lower our colours in order to secure the Queen's badge or any similar distinction."[69]

In 1892 a Nurse Blackmore at Stamford was dismissed for converting to Catholicism, and the affiliation committee resolved not to supply further nurses for the Stamford Association.

An affiliated association in Wolverhampton was confining its nursing to a small district consisting of two parishes with a population of 1,500 (out of a total population of 82,000). In 1894 the affiliation committee expressed concern that the nurses were forbidden to work outside of these parishes, and that the Roman Catholic population was unwilling to avail themselves of the services of the nurses, as they were looked upon as "St Luke's and St Paul's nurses."[70] No satisfactory explanation was received from Wolverhampton and the association was disaffiliated.

Despite these concerns regarding organised religion and district nursing, it will become apparent that Sisterhoods and other religious organisations continued to exert an influence on district nursing associations, both in terms of an enduring religiosity, and in providing an organisational framework, even as they became more secularised later in the century.

Conclusion

The emergence of Sisterhoods and orders of Deaconesses provided the opportunity to respond to a need felt especially among the emerging middle, and the upper classes for a reliable, competent nurse during times of illness. Whether this need was real or, as Rafferty (1996) states, part of the marginalisation of domiciliary nurses in order to justify incorporating them into a medically controlled institutional system, it certainly provided much of the rationale for the foundation of many institutions. Those founding Sisterhoods had discovered a niche market, an area of work which they seized by creating a nursing service based on piety and devoted service. This could then be demarcated from what was commonly perceived as unreliable and disreputable domiciliary nurses, who were previously available.

By introducing a form of training, albeit mainly observation in the large voluntary hospitals, Sisterhoods provided a transition between the older type of nursing, which was analogous to domestic service, and the later professional occupation, with its more systematic technical training. They also provided the organisational catalyst for later district nursing associations. This transitional period saw the status of the hospital and formal training elevated to that of protector of the public interest in regard to caring for the sick, and the 'natural' location for training to take place. This will be a focus of the next chapter.

The importance laid on trustworthiness and character, and the provision of written testimonials were major selling points for nursing organisations (Summers 1991), and assuaged the concerns of middle class patients regarding the type of nurse they were allowing into their homes. That the nurses were perceived as trustworthy can be concluded by the fact that most organisations

had problems meeting the demand, and often did not have enough nurses to send gratuitously to the poor. It should not, however, be forgotten that the clergy also benefited from the presence of nursing Sisters, by delegating to them the task of sick visiting.

For the Sisters and Deaconesses themselves, these orders of women provided an alternative, whether consciously sought or not, to marriage and dependence on men. It is open to question whether this symbolic reward for their labour, or a life of devotion was the main motive for entering. The cloistered existence of most Institutions, and the unquestioning acceptance of patriarchal power relationships makes it unlikely that these women actually achieved independence. Male representations of female behaviour determined the organisation of the Institutions. This created an image of nursing, which was later extended to hospital nurses, as pious, self sacrificing, and obedient. The Ranyard mission, on the other hand, remained an organisation of women, for women. A hierarchical division of labour was evident, based not on gender and social class, but on social class alone (Denny 1997).

All the nursing institutions organised around a religious sect utilised a social class hierarchy, in order to inculcate the lower class nurses with certain values which they were to pass on to their patients. The distinction was between those who took vows and those who did not; or those who were paid and those who were not. Being part of the official or subjective labour force determined what work tasks a nurse carried out, her position in the hierarchy, and her degree of autonomy or control. The assumption was that it was only women of high social status who would possess the correct moral qualities, and the willingness to do nursing work from non-pecuniary motives. Turning work into an

occupation by accepting money in exchange, would have resulted in a reduction of status. The payment of commission by the Institute of Nursing Sisters, and later by St John's House, however, indicates a commercialism, which is hard to reconcile with pious and dedicated service, but which demonstrates an occupation's ability to act simultaneously in both an altruistic and a self interested manner. The fusion of vocation and paid labour, of the subjective and official economies, is an enduring feature of nursing.

From the organisations described in this chapter, district nursing expanded during the second part of the nineteenth century to become more secular, although retaining a broadly Christian base, and espousing an image of pious service adopted from the Sisterhoods. Later associations, including Sisterhoods, employed salaried nurses, while continuing to use philanthropic labour in addition. The way in which these associations developed outside of organised religion will constitute the remainder of this thesis.

Notes

[1] An exception to this, according to Musgrove (1979), was in cathedral cities.

[2] The census did, however, have its limitations in that many churches did not complete returns, and the returns noted attendance, rather than the number of people who attended. The Registrar General compensated for attendance at more than one service by a formula that worked to the disadvantage of Non-conformists (Dennis 1984)

[3] According to Jameson (1855) the country surgeon was a Dr. Gooch, a physician and philanthropist.

[4] The suspicion that convents had a subversive influence on family life was treated seriously by Sisterhoods, who strongly rejected any such charges levelled against them (Hill 1973).

[5] LMA H1/ST/SJ/A33/2 Annual Report 1857:20

[6] Bodleian 1847.163 'A memoir of Elizabeth Fry vol.2 edited by her daughters' (1847):383

[7] LMA NC/15/8 Annual Report 1853:5

[8] ibid

[9] ibid

[10] later increased to 3 months

[11] BL 4193 cc 101 Edwards E J (1865) 'Nursing association for the diocese of Litchfield'

[12] The issue of sobriety and nurses' conduct is somewhat problematic, and will be discussed in more detail in chapter 7

[13] LMA NC/15/8 Annual Report 1853:7

[14] ibid:8

[15] Wellcome SA/QNI/W Committee minute book

[16] ibid

[17] quoted from BL 4193 cc 101

[18] LMA H1/ST/NC/15/13a&b Report of the sub-committee of reference and enquiry on district nurses in London:56

[19] ibid

[20] LMA H1/ST/NC18/3/4/1 Printed prospectus:1

[21] ibid:2

[22] That nursing should be a vocation, not sullied with pecuniary matters has been a recurring theme in the history of nursing, and a contributing factor in the registration debate of the early twentieth century.

[23] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town':64

[24] Bodleian 210 m 2 'Memorials of Agnes Jones by her sister' (1871):135

[25] LMA H1/ST/SJ/Y10 'St John's House - a brief record of sixty years work' 1908

[26] LMA H1/ST/SJ/A1/1 Committee minute book 1847-8

[27]LMA H1/ST/SJ/Y8 'A short history of St John's House and Sisterhood' 1867:3

[28] LMA H1/ST/SJ/Y10 'St John's House - a brief record of sixty years work 1908:4

[29] LMA H1/ST/SJ/A2/1 Council minute book 07.04.1849

[30] ibid

[31] LMA H1/ST/SJ/17/1:2 Resolution for the opening of St John's House 1848

[32] Some sisters were resident in the home, and made the Institution their life's work, but others entered for part of the year only, or lived outside. For example, one of the Sisters, a Miss Helps, had a sister, Katherine, who entered temporarily to visit the poor in the district, and help in any way she could.

[33] LMA H1/ST/SJ/A2/1 Council minute book 21.04.1849

[34] LMA H1/ST/SJ/A19/1 Lady superintendent's report 07.10.1848

[35] ibid 26.05.1849

[36] LMA H1/ST/SJ/A19/2 Lady superintendent's report 18.06.1849

[37] Mrs Jay and Mrs Dick seem to have been dismissed for not obeying the doctor's instructions, which will be explored in chapter 7, when the issue of control of nurses' work is considered

[38] BL 7686 aaa 33 Rathbone w (1865) 'Organisation of nursing in a large town' 1865

[39] LMA H1/ST/NC/15/13a&b Report of the sub-committee of reference and enquiry on district nurses in London:59

[40] LMA H1/ST/SJ/A33/2 Annual Report 1857

[41] It has to be remembered that gentlemen and players came from different social classes anyway.

[42] LMA H1/ST/SJ/Y10 'St John's House - a brief record of sixty years work' 1908

[43] ibid:3-4

[44] LMA A/RNY110 Missing Link 1874:228

[45] LMA A/RNY104 Missing Link 1868:33

[46] It is difficult to ascertain from Ranyard's writing whether she actually rejected the gender division of labour based solely on task distribution in all aspects of life, or whether she thought that the usual patriarchal power relationships were inappropriate in areas of life, such as nursing, that were perceived as inherently female.

[47] LMA A/RNY104 Missing Link 1868:134

[48] ibid:133

[49] LMA A/RNY105 Missing Link 1869:102

[50] ibid:2

[51] LMA A/RNY109 Missing Link 1873:12

[52] LMA A/RNY104 Missing Link 1868:249

[53] ibid:218-9

[54] LMA A/RNY105 Missing Link 1869:88

[55] ibid:171

[56] ibid

[57] LMA A/RNY110 Missing Link 1874:42-3

[58] LMA A/RNY104 Missing Link 1868:302

[59] LMA A/RNY107 Missing Link 1871:221

[60] LMA A/RNY105 Missing Link 1869:323

[61] ibid

[62] ibid

[63] LMA A/RNY106 Missing Link 1870:323

[64] ibid

[65] LMA A/RNY107 Missing Link 1871:395

[66] LMA H1/ST/NC16/8 A physician (1860) 'On the employment of trained nurses among the labouring poor':29

[67] Derby Studies Centre A610.73 Report of meetings 1865

[68] Wellcome SA/QNI/N.6/3 'Queen Victoria's Jubilee Institute for Nurses: it's object and its work' Lecture delivered by Peile A.

[69] LMA A/RNY127 Bible Work at Home and Abroad 1892:225 (The Missing link was renamed in 1885)

[70] Wellcome SA/QNI/C2/3 Affiliation committee minutes 27.02.1894

CHAPTER 7

The organisation of the work

Introduction

It will have become apparent from the previous chapters that there was no systematic attempt to develop district nursing, which began in an uncoordinated and *ad hoc* manner. Sisterhoods had little in common at an organisational level with the philanthropic endeavours of Rathbone or Ranyard. Apart from some correspondence between those preparing to start up and those already underway requesting advice there was little communication between them.

Thus far I have used the term 'task' in a taken for granted manner, yet Dingwall (1983) questions where the tasks carried out by an occupation come from. As discussed in chapter 3 the work involved in district nursing had been carried out informally within the home before a paid occupation evolved, and it has been argued that social change created the market conditions in which district nursing could emerge. The rise of capitalism brought a move to more waged labour which took place outside the home, so that households had little time to incorporate caring tasks into the daily routine. This provided the opportunity to use district visiting to carry out those tasks and, at the same time, convey middle class values to the poor. Waged work developing outside the home facilitated the development of another role within it, using both official and subjective labour. The tasks, then, were always there, only the

agent changed as district nursing became a philanthropic and, increasingly, a paid occupation. As district nursing developed other facets of the role became apparent, and these will be discussed in the next two chapters.

To what extent did the *ad hoc* nature of its origin result in different working practices? Training has already emerged as a central issue, and similarities and differences in ideas about training will be considered, with a particular emphasis on what it was intended to achieve. In thinking about the actual work carried out, I wish to use ideas about what was considered appropriate work to be undertaken by the nurses, to explore the concept of jurisdiction. Did the tasks constitute a defined body of work over which district nurses could claim jurisdiction? The relationship between private duty and district work is crucial here. In this chapter these questions will be addressed by looking at internal boundaries, training, the relationship between nurses and superintendents, and the work undertaken by a variety of associations.

The concept of occupation is therefore being addressed both as the delineation of tasks and as social activity.

Fever and infectious diseases

The Oxford cholera epidemic of 1854 provides a well documented case study of an *ad hoc* response to a problem, and an early example of district nursing. It also demonstrates the nature of women's work, described in chapter 5, as often temporary, with an overlap between domestic and paid work.

Cholera had been epidemic in Oxford in 1832, 1849 and 1854. In each of these three years provision was made for the care of sufferers in a separate hospital, the Radcliffe Infirmary having refused to take infectious cases. It had been

noted in 1832 and 1849 that the chance of recovery was less for those who were removed from home, and there was also prejudice associated with admission to the 'pest house'. So in 1854 arrangements were made to provide nurses and supplies to the homes of all poor patients.

A list of "all the respectable women who were willing and able to nurse in cholera houses"[1] was kept in the police office, most of the names being furnished through the local knowledge of the parochial clergy. When a new case of cholera was announced in the home of any poor person, a messenger from the police office went to the house of a nurse who was between patients, and sent her there. Then an Inspector Condé visited to ascertain whether the house was in such a condition that the orders of the medical attendant could be followed. If not he sent whatever food or supplies were required from the police office.

> And lastly, because most important, a lady .... visited daily every house (within a certain area) to instruct the Nurses, to comfort the sick, to cheer the disconsolate: and where need was, herself to supply a sudden emergency, or to relieve a wearied attendant.[2]

The epidemic started at the end of the long vacation, and as so many townspeople were reliant on the university for trade they were not earning enough at the time to feed themselves properly. Therefore a system of food distribution was set up from the town hall. The lady superintendent wrote "In Orpington's Yard three deaths had occurred, and every house had diarrhoea; after the food was given there were no more fatal cases and the complaint was checked."[3]

Acland felt that lessons could be learnt from the epidemic:

> Far more important than a revolution in Hospital nurses appears to me the obtaining nurses trained and qualified to attend the poor at their own homes. There is no object requiring the energy of the benevolent; none more certain to repay their exertions; none more easy of executions.[4]

He recommended that a corps of nurses be provided at all times to attend the sick. The more able could become trained nurses for all classes and would be certified. It probably would have been attempted directly after the 1854 epidemic had not the nurses for the most part gone to the Crimea, and it was not until 1879 that a system of district nursing was attempted for the poor in Oxford by the Acland Home.

Short lived schemes such as this were usually a response to epidemics, and were often the result of a request by the Poor Law Guardians or local clergy. In 1858 Acland went to the parish of Great Horwood, Buckinghamshire in order to observe an endemic fever at the request of the clerk to the Winslow Board of Guardians. He recommended that "A competent superintendent nurse go round to the cases daily and see that the advice of the medical officer is carried out, and to report to him where, why and in what there is difficulty in obeying him."[5]

When requested St. John's House nurses would also go to towns outside London on a short term basis, during epidemics of typhoid and enteric fever, as described in chapter 6. Acland does not mention the risk to the nurses of this type of work, although the annual reports of St John's House do record deaths of nurses from fever caught while nursing. Some associations, like the Ranyard Mission and Stratford, would not nurse infectious diseases at all, and some had

a separate 'fever nurse'. In Derby the fever nurses reported daily to the lady superintendent over the garden wall of the nurses' home.[6] The lady superintendent of the Acland Home would not go out with the district nurses to infectious cases. Florence Lees in her survey of district nursing provision reported instances of nurses not washing between infectious and surgical cases,[7] and possibly as a result of this observation nurses from the Metropolitan Association attending fevers and other infectious diseases were limited in their attendance at other cases.

The nursing of fever and infectious diseases was an example of a category of district nursing that was often short lived, and one that emerged as a response to a perceived need. It provided care for the sick poor, but was also useful in controlling their movements and behaviour during an epidemic. It also demonstrates the differences between associations on what were considered appropriate district nursing tasks.

Training and supervision of district nurses

Because of the diverse and unregulated nature of district nursing in the nineteenth century, and the fact that organisations were charitable societies reliant on donations and subscriptions, or income from private work for their existence, it is not surprising that how they were organised, what work was undertaken and how nurses were supervised differed. Being for the most part small, local organisations the type of work would have responded to local need, at least as it was perceived by the controlling authority. This section will address two issues which illustrate this diversity, training and supervision of nurses, and the next section will consider examples of the work undertaken.

Most associations had very few district nurses - one or two being the norm. The Ranyard Mission was the largest with 48 nurses, followed by the Institution of Nursing Sisters with 20. The total number of district nurses in London in 1875 was 106 (Denny 1997), for a population of 3.5million. Nightingale wrote to the Reverend H.D. Acland[8] in 1879 that "there is no 'supply', there is a great 'demand'."[9]

Probably the greatest variation between associations was in the amount of training thought appropriate and possible. Some associations, like the Ranyard Mission, wished only to provide nurses for the sick poor, and sent them for training at one of the London hospitals for three months. Others like the Liverpool School and the Institute of Trained Nurses for the Town and County of Leicester[10] started a nurses' home for training nurses for hospital, private or district work, the allocation of nurses to each being the responsibility of the superintendent. The Worcester City and County Nursing Institution[11] sent nurses for training for six or twelve months, and divided them into 'ordinary' and 'fully trained' nurses. As stated in chapter 6, St John's House trained nurses for KCH and Charing Cross Hospital as well as providing private nurses and some district work. Yet other organisations only employed nurses who were already trained, for example Stratford and the Acland Home. The Liverpool School set the standard by setting its training at one year in a hospital. This was adopted by many associations for some years, and it was not until the turn of the century that it was raised. A shortened training for women with nursing experience was often thought sufficient.

The Metropolitan Association felt that the one year hospital training should be supplemented by six months training in district nursing, needed because of the

different conditions in private homes and the fact that doctors were only in attendance periodically.[12] In her first quarterly report Lees quoted a physician from one of the London hospitals who, on reading a nurse's report of a patient said "Really women of this kind will be invaluable among the sick poor; I doubt if many of our medical students could have sent such a report." Lees added:

> I could add to this many other instances to show that the higher the training the more useful the nurse, and how essential it is that the nurse should be thoroughly trained for district work, is more fully proved by the experience we now have among the sick poor.[13]

Nightingale also felt that it was only through training that nurses would learn to really nurse, and not degenerate into givers.[14]

Training was mainly clinical, supplemented by some lectures by physicians, especially towards the end of the century. Mary Cadbury, who was trained by the Metropolitan Association in 1878 wrote to her mother:

> Three evenings a week there are lectures .... I do enjoy [them]. I forget if I told you what they were on Tuesday by Dr. Cheadle on hygiene, Wed[nesday] by Warrington-Hayward on anatomy and perhaps the most interesting on Friday by Haywood-Smith on physiology. We have to study hard for them all and this is very nice as we have time given us for it.[15]

Training was not, however, just a matter of theoretical lectures, and by 1889 St. John's House was awarding certificates to nurses on completion of training, half the marks being reserved for conduct and practical work. "Care has been taken to avoid the danger of attaching undue importance to mere theoretical knowledge, to the exclusion of the even more necessary qualifications of a true nurse - namely character and practical ability."[16] The perceived importance of

'character' for nurses has already been noted. The structure and form of nurses training reflected the gender and class constraints which characterised contemporary attitudes regarding the education of girls (Rafferty 1996), and reflected the image of nursing which originated with the Sisterhoods.

Not all, however, agreed on the superiority of trained nurses. In 1869 Charles Langton wrote to Bonham-Carter that some of the superintendents in Liverpool actually preferred untrained nurses, and others preferred to hire cheaper nurses, and to use the difference in wages on extra relief.[17]

The biggest variation in training was between the Ranyard nurses and other trained nurses. In 1875 when Lees conducted her survey of district nursing they were receiving three months hospital training in order to observe a large number of conditions in a short time. The length of training was not increased until Mrs Selfe Leonard succeeded Ranyard, and it was 1893 before a one year training was given. Ranyard strongly defended her nurses' training stating that by using "the right native agent"[18] bible nurses could be trained more quickly to fulfil most of the requirements on Nightingale's list, and they were better prepared than trained ladies for the "dirty, shiftless, wretched poor."[19] The Missing Link published testimonials from medical officers to support her case. She claimed that her nurses undertook all the tasks suggested by the proposed new nursing service to the sick poor.[20]

Training for district and private duty nurses began in some hospitals before the Nightingale school opened in 1860, at a time when hospital training, if it existed at all was perfunctory. This begs the question - why train nurses in hospitals at all? It has already been observed that that domiciliary nurses constituted 70% of all nurses before World War One, and that hospitals were

not considered suitable places for ill people, so why were they considered the appropriate places for training? Nightingale, in a letter to William Rathbone stated:

> I quite agree with you that missionary nurses are the end and aim of all our work; hospitals are after all but an intermediate stage of civilisation. While devoting my life to hospital work, to this conclusion I have come viz., that hospitals were not the best places for the sick poor, except for severe surgical cases.[21]

The professed reason for hospital training was for nurses to observe a large number of conditions in a short space of time, but as voluntary hospitals (where most training took place) were very selective in the type of patients they admitted this argument does not appear very plausible. Voluntary hospitals would not accept patients with chronic conditions, consumption, or patients who were likely to die, the very patients most commonly seen by a district nurse. It would have been more appropriate, then, to train nurses in dispensaries, which saw an immense variety of conditions. Indeed St John's House in 1849 bought a house and turned it into a sanatorium where probationers could learn the skills they needed to be efficient private duty nurses, but which could not be learnt in hospitals.[22]

If, however, we look not at the actual training but at the nurses themselves, in other words consider the occupation not in terms of its tasks but as a social activity, other reasons for hospital training suggest themselves.

All domiciliary nurses worked, as now, fairly independently, any supervision, especially that by lady superintendents, being more concerned with how the nurse conducted herself than with the treatments given. Many patients would

not have been under the care of a doctor and even where they were, nurses would not necessarily see their function as following orders. Their methods of working may have in some instances run counter to that of the doctor. General practitioners, in particular, saw private duty nurses as a threat, competing for the same market, at a lower price.

Reference has been made throughout this thesis to the fact that medical men objected to the autonomy and independence of domiciliary nurses, and to Rafferty's (1997) argument that hospital training was designed to curb this independence. Summers (1989), too, points to contemporary literature laying great stress on a nurse's ability to follow a doctor's instructions meticulously, not just in terms of possessing the intelligence to carry them out, but more importantly in terms of the willingness to defer to his judgement. As the century progressed and the length of hospital training lengthened, nurses in private homes and districts came more under the control of hospital authorities and were expected to be deferential to doctors and to unquestioningly carry out medical instruction.[23] Hospital training taught nurses obedience in a way that would have been difficult in any other arena. The image of the nurse created by the Sisterhoods was reinforced. Indeed Nightingale advocated that district nurses be 'retempered' every two to three years in hospital, as they would not be able to keep up to the standard of hospital nurses without trained superintendence and with "no practical obedience to the doctor."[24] As district nurses worked independently the message of obedience needed to be periodically reinforced .

Support for this argument can be found in contemporary literature. The Ranyard Mission stated in 1874 that the main value of a hospital training was

to teach nurses to refer to medical authorities and to carry out their instructions,[25] and a nurse for the Derbyshire Association was dismissed for administering a medicine with the intention of concealing it from the doctor.[26] Acland nurses were not allowed to give treatment except under the precise instructions of a registered practitioner. Other cases to which a nurse was called could be placed "under observation" and visited occasionally, but she was forbidden to incur any responsibility for their treatment.[27] Mention has already been made in chapter 6 of Mrs Dick and Mrs Jay, St John's House nurses who were dismissed for neglecting a doctor's orders.

Training in hospital was used in order to regulate the work of domiciliary nurses by restricting it to the carrying out of doctors' orders, thereby bringing them under medical control, with a consequent loss of autonomy as independent practitioners. The medical profession enhanced its power by creating a boundary between medical and nursing work, and by controlling the work of nurses. Demarcation was used to differentiate what medicine did from what nursing did, and to keep nursing subservient.

In country districts diversity between associations was even more marked. Even within a county association training varied from none to one year. The most common training undertaken was the London Obstetrical Society (LOS) certificate, as attendance on mothers and babies was the most frequently undertaken work. A questionnaire by the rural district nursing sub-committee of the Queen's Institute found that many rural associations undertook this work, although many would not combine it with actual midwifery.

The Cottage Benefit Nursing Association, started in 1883, did not consider hospital training appropriate for cottage nurses, and although sending nurses to Plaistow to obtain the LOS and elements of sick nursing from a Sister Katherine Twining, instruction was mainly given at ambulance classes. This consisted of dressing wounds, bandaging, leeching, giving enemas, preventing and dressing bedsores, invalid cookery, hygiene, and observing symptoms.[28] Bertha Broadwood, the founder of the association, considered that the needs of country people were different from those in towns, and that trained nurses would be regarded with suspicion. Where they had been supplied, at great expense, cottagers would not employ them, but "preferred to muddle along and make out, with the chance of occasional help from some neighbour."[29] Broadwood considered that it would be a waste of a trained nurse's skills for her to be employed in cooking and housework, and yet in isolated country homes where help was hard to get, a nurse was of little use unless she could stay in the cottage or farm and help with the family when not nursing the patient. As the way of doing things was different from one place to another, a local nurse who knew the area and was "acquainted with its rough cottage work"[30] was considered the best sort. Like Ranyard, Broadwood believed in using 'native talent', as she found that a plain working woman was more welcome than a professionally trained nurse, who would probably not find enough to do in a small parish. Yet the cost of a trained nurse was around £40 *per annum*, and all those who were approached said that they would not do menial work, and only attend to the patient.

Elizabeth Malleson, who founded the Rural Nursing Association in 1889 perceived the needs of country districts quite differently. All affiliated

associations employed only trained nurses as "the more isolated the district and the more remote from medical aid, the greater the need for a trained woman within call."[31] The nurses lived in their own homes and provided a visiting service, as there was not room in most cottages for a resident nurse and her maintenance would tax household resources too much. Malleson also wanted to see educated women taking up the work, as they could have more influence over the poor. Except for midwifery, nursing was provided gratuitously.[32] It would seem that more remote areas, without the proximity of doctors, were less influenced by medical demarcatory politics, and more by local characters. The existence of these different types of domiciliary nurses made it difficult for a single occupation to develop with a recognised training and discrete area of work, and this had consequences for professionalising strategies at the end of the century. These issues will be explored in chapter 8.

Whatever training was given, all nurses were supervised in their work, either by a trained or a 'lady' superintendent.[33] Some, like Miss Brumwell at Derby were both, and some, like Miss Minet at Stratford undertook the district nursing work of the Association. Before the employment of Miss Minet a parochial nurse had been employed at Stratford for district work, but it is not clear from the annual reports whether she was retained.

The Ranyard Mission justified their use of 'native agents' as district nurses because they were frequently assisted and inspected by "some intelligent superintendent."[34] The philosophy behind this is similar to Hughes' (1971:83) concept of the 'straw boss'. This he describes as "a liaison man (*sic*), a go-between", who was evident in colonial areas and in 'mother countries'. Some

of the characteristics that Hughes attributes to the first of these arenas can be seen to fit the role of Ranyard nurses. The straw boss was given a supervisory role over native workers, as he knew the peculiar ways of the workers, which were held to be different from the elite within the organisation, and could deal with them accordingly. He documented the gap between the higher and lower status positions, but was not himself considered a candidate for any higher position. The Ranyard nurse would have a knowledge of the type of patients she visited, coming form the same social class, and her function was to instil the poor with middle class values of thrift, hard work and self reliance. She would report their needs back to the real authority (the lady superintendent) who would decide on what help should be given. Ranyard nurses could never become superintendents themselves.

The lady superintendent in the Acland Home kept the accounts of the home, as well as supervising the nurses. She visited all cases with the district nurse weekly, which was probably more 'hands on' than most associations. She received the nurses' daily reports, inspected their diaries, arranged their work for the day and kept records of all cases. All this she reported to the committee. The lady superintendent in Derby gave medical comforts and supervised the nurses, arranging each day's visits.

Some associations like the Ranyard Mission, saw one of the main duties of the lady superintendent being to ensure that nurses did not give relief, and to aid in securing supplies. It was envisaged that each Ranyard nurse should have a lady superintendent, as the 'native agent' needed proper supervision. The lady superintendent at the Mother House also visited patients with nurses. Every week the nurses would attend the Mother House where six lady volunteers

would have prepared packages of clothing that she had requested, and go through the case notes and the nurse's account of supplies to compare it to what was issued to that nurse.

Liverpool began in 1859 with a lady superintendent who visited all cases to ensure the nurse was working well, examine her register and hear her reports. Within four years every district had a lady superintendent, and trained superintendents were in charge of each district home and took responsibility for the professional aspects of the nursing school. Rathbone himself took the place of one lady superintendent for a year during her absence (Rathbone 1905). This division of labour between trained and lady superintendents was influenced by Nightingale who thought that no nurse should be supervised by a non-nurse, and no nurse should be involved in obtaining relief. The significance of this for the professionalising process will be taken up in chapter 8, but it is worth noting here that paid superintendence grew out of the role played by lady superintendents. As both Freidson (1978) and Prochaska (1980) observe, volunteer labour is often the germ of official occupations, but in this instance it could only evolve as paid labour became more acceptable for middle class women, towards the end of the century.

In Leicester the trained superintendent supervised the private nurses in the home, and was only nominally over the district nurses, who were supervised by an honorary superintendent, in Mortlake and Buxton the honorary secretary of the association inspected the nurses' casebooks, each of these only having one nurse. The Worcester Institute employed trained superintendents, but the first of these requested a lady to assist her and act as deputy.

The presence of lady superintendents clearly demonstrate the inadequacy of existing theories of professionalisation in accounting for the genesis of occupations. Until paid superintendence became the general rule, these women played an important role in district nursing associations. As described in chapter 5, they conformed to Summers' and Prochaska's notion of philanthropic pursuit as often quite expert work, involving much time and sacrifice. Their legitimacy was gained by the perceived superiority of the subjective economy, in which they were able to engage because of personal wealth or domestic patronage. Their reward was symbolic, authoritative acceptance in the world of work.

The work of district nurses

Little has been said until now about the official workforce in district nursing, and this section will consider its function and the work it undertook. It has been argued that the different tasks undertaken by domiciliary nurses led to a heterogeneous occupation, which was a limiting factor in the attempt to professionalise. In examining this I wish to draw on the different approaches of Freidson and Abbott in conceptualising 'task'. Freidson (1994) states that as task forms the link between organisation and experience it must form a key dimension of analysis, yet the associated ambiguities, such as the fact that occupations perform a set of tasks, rather than a single task, present a formidable obstacle to analysis. Abbott (1988) argues that tasks are important in defining an area of work over which an occupation can claim jurisdiction. He also recognises the subjective way that tasks are constructed by those holding jurisdiction. For an analysis of a heterogeneous occupation like district nursing,

the set of tasks undertaken by it, and the subjective way they are constructed is crucial. This section will, therefore, illustrate the work of the different district nursing associations, and the next section will consider their relationship with private duty nurses.

Nursing care was always given to paying patients, but the work carried out with district patients varied in different associations. Some associations saw their role with the poor as overseeing the care that was given and instructing relatives, which may explain the large numbers of visits made by some nurses. In Stratford in 1874, for example, 3,060 visits to the sick poor were made. On its inception in 1865 the Derbyshire Association also had the objective of disseminating information regarding prevention of disease and the primary laws of health. It was intended that what was called the 'sanitary work' of the Association should consist of the distribution of pamphlets, the delivery of lectures and the appointment of sub-committees to report on matters of health. By 1870 it was reported that the sanitary work was restricted to what the nurses were able to do in regard to cleanliness and ventilation. Other associations were less ambitious and, like the Metropolitan Association, saw their role as ensuring cleanliness and reporting sanitary defects to the Medical Officer of Health.

This difference in the type of care given did not constitute two distinct types of nursing with a demarcation of tasks between private duty and district nurses, as nurses went between the two types of work, often within the same job. It rather reflected ideas about the type of patient being nursed. Work carried out by private duty nurses was determined by the paying patient, whereas the district nursing association defined appropriate tasks for district nurses to undertake.

The significance placed on instructing the poor in sick nursing and cleanliness, and dissemination of the sanitary idea reflected middle class ideas about cleanliness and hygiene (as discussed in chapter 5), and working class failure to conform to them without instruction and supervision. It also distinguished the work of district nursing from that of handywomen.

Nursing care was always given by associations like the Ranyard Mission and the Metropolitan Association, which only worked with the sick poor. It was associations which mixed private and district work which did not always provide nursing to the poor.

In Stratford, for example:

> The immediate objects of these visits has been to see that the poor are properly tended and dieted - their wounds dressed - poultices etc. carefully made and applied. Instruction is at the same time given in matters of order, cleanliness, ventilation and sick cooking.[35]

The Stratford Home did, however, perceive the district visits as the most important branch of their work.

Most associations would not combine nursing and midwifery although some did visit lying in patients and their babies. Midwifery was seen as a lower status occupation by many associations, and would not have attracted the educated women that they were seeking. The Acland Home opened a separate maternity branch in 1887 for those provident society members living beyond the limits of the Oxford lying in charity.[36] In 1895 Leamington Spa was refused affiliation to the Queen's Institute because it undertook midwifery. As reported above, this situation was completely different in country districts, where often a scattered population could not have supported a nurse and a midwife, and a wider range

of tasks was undertaken. As in Oxford maternity work was often provided only to provident patients.

Medical and surgical cases were frequently nursed, and despite Lee's criticism of Ranyard nurses on the point, Metropolitan nurses exclusively nursed this type of patient in the early years. Many operations took place in the patient's home, and a nurse's report of 1875 spoke about a very serious operation on a woman:

> The parish doctor stated that had he not known how thoroughly well trained our Nurses were, he dared not have performed the operation in the woman's own home, although by her not going into hospital, the parish was saved a guinea a week, and the poor woman' home was saved from being broken up.[37]

Also commonly nursed were incurable patients and those with chronic conditions, who were not accepted by the voluntary hospitals. By 1898 the Stratford Association was giving most help to chronically ill and bedridden patients. The Worcester Institute was the only association considered here to nurse what it called 'mental cases', which is not surprising as this was generally associated with custody and restraint, rather than caring.

The work undertaken by district nurses is most graphically illustrated by the description of cases often reported in supervisors reports and annual reports of the organisation. They tell of operations being carried out in patient's homes, as illustrated above, and give an indication of the type of conditions nursed. These are obviously second hand reports, sometimes even third hand if they were written down by a lady superintendent and then reported in an annual report. Nurses' records and notes were rarely thought worthy of retention.

Case reports were often used by associations in order to encourage donations,[38] and so as a representation of district nursing work they may be biased towards the sensational, and that which invokes sympathy. Since documented comment by patients is limited to unsolicited communications, it suffers from the limitations discussed in chapter 2.

The Acland Home rarely gave details of patients, but an exception was made in 1898 when a very matter of fact report was given.

> **Patient found in delirious condition from pneumonia in attic, with no fireplace**. Nurse arranged removal in a sheet to lower room. After five days the patient died and the husband fell ill and died a week later from hard work and want of food. Nurse visited three times daily.
> **Puerperal case** Very seriously ill. District nurse found it impossible to leave. Husband came home drunk. This a case which shows the need of a trained district nurse for night work.[39]

The Missing Link, on the other hand regularly contained graphic accounts of case studies. Some of those associated with conversion have been cited in chapter 6, but others focused on a description of the patient. An example from 1869 was of a man who had been disabled for four years following a brain abscess. He lived with his wife and children on parish relief, and all their furniture had been sold to pay for rent and food. The nurse loaned them sheets and blankets, but no hospital would admit him because he was incurable. He was eventually admitted to the workhouse infirmary, but the fate of the wife and children is not documented.

Apart from the occasional bad report from patients, associations, not surprisingly, wrote in glowing terms about their own nurses, and the following example from the Derbyshire Association is fairly typical:

> Many of the poor were found in a condition that cannot be described, and none but women who were not only trained, but worthy of the name of nurses could have dealt with some of these neglected, suffering creatures .... [T]he self denying manner in which the nurses have attended them, doing for them what none else, not even the kindest neighbour would, is worthy of high praise.[40]

They also took the opportunity to demonstrate the superiority of their nurses over others. The Metropolitan Association described a case of concussion and severe scalp injuries taken over from an untrained parish nurse. The doctor in attendance called in the Association when he felt that his instructions were not being carried out.

> At our first visit we found the patient lying on the bed in the clothes she wore when she received the injuries a week before. The clothes were covered in blood, and dirty beyond description. .... The doctor had given strict orders that she should not be moved, so the Parish nurse had left her in the state she found her, not knowing how to wash her, take off her clothes, or make her bed without the removal of the patient.[41]

The undated report of a lady superintendent in Liverpool describes the conditions in which even the working poor sometimes lived:

> Afflicted with asthma and other diseases. Found lying on the floor, covered with bedsores, and so thin she had to be lifted on a sheet, her husband is a porter with two children, unable to pay for nursing; she was attended by the Dispensary Doctor but in other respects was left to the mercy of the world in a low neighbourhood in dirt and bad air, wretched in body and mind causing her husband to feel wretched also on coming home and finding his house in such a condition .... our nurse comes in and washes her and lends a bedstead and bedding, shews (*sic*)

how to use an air cushion, changes the linen etc., cleans the house, persuades the husband to whitewash the apartments; stable nourishment is sent and she and the household are now in comparative comfort .... The man is now helpful and hopeful and had added by his own exertions and savings to the comfort of his home.[42]

The above discussion suggests a diversity of working practices and tasks between district nursing associations, within a larger collection of tasks. Freidson (1994), while accepting the necessity of delineating occupation in part by its tasks, does not consider whether the set of tasks is the same for all members, or whether, as I have suggested, it falls within a larger collection of tasks, which facilitates the development of diversity within an occupation. It is useful here, in attempting to make sense of the tasks of district nursing, to re-iterate Abbott's (1988) thinking on 'task'. He argues that the tasks of professions are human problems which are amenable to expert service, but that the degree to which this occurs is variable. He also points to the subjective way in which tasks are constructed. This has already been noted, in the earlier discussion of the gender division of labour based around task distribution. This section has leant support to this view through a description of district nursing tasks which conforms to an extension of the female domestic role.

Although district nursing associations were able to seize the work of nursing the sick poor in their homes, the *ad hoc* nature of their emergence had implications for occupational identity. The diverse nature of the tasks undertaken meant that although a single occupation could be delineated, a discrete area of work could not, which was a crucial factor in attempts professionalisation later in the century.

The relationship between private duty and district nurses

The previous section noted the difference between the care given by private duty and district nurses. I intend to continue this theme by highlighting the tension between private duty nursing and district nursing, demonstrating the importance of viewing occupation as both a collection of tasks and a social activity. This tension was mainly due to the need for most associations to maintain their income, in terms of the nurses themselves the position was not as dichotomous as might be imagined. I intend to demonstrate that there were not two different occupations, carrying out distinct tasks but, as argued in the previous section, the same occupation was being carried out differentially according to the client group. This demonstrates Freidson's (1994) assertion that the social contingencies of task can vary within an occupation, part of which is a differentiation into specialities and segments. Nurses moved between the two types of work, albeit not always easily, both within and between associations.[43] Private patients defined the relationship with the nurse, and decided what work was to be carried out. District nursing associations decided what work they would carry out with the sick poor, so power relationships were the result of a pecuniary relationship.

Florence Lees, in her 1875 report on district nursing, stated that where associations provided both private duty and district nurses they gradually 'declined' into private nursing associations.[44] This was probably because of the higher wages offered, and the fact that many nurses preferred private nursing, as they were continually employed in comfort.[45] Most institutions could not successfully combine the two. There was also an imperative towards work that would bring a reliable income to associations which continually faced financial

uncertainty. We have seen how district nursing had to be severely curtailed by St. John's House following the termination of its training contracts with KCH and Charing Cross Hospital. Nightingale cites the example of the Westminster Hospital Nurses' Home, which began in 1874, with the Lady Augusta Stanley fund to be used for district nursing, but which by 1887 had a large private nursing staff and no district nurses.[46] Rathbone in the same year, and probably influenced by Nightingale, strongly recommended that Queen's Institute nurses were used exclusively for the poor:

> .... and the best nurse should not be absorbed by the demands of the rich, as has hitherto been too much the case in those societies especially which attempt to provide nurses both for the rich and poor and where the larger part of the funds of the society are derived from the earnings of the nurses who attend upon the rich.[47]

The Liverpool School kept the nurses to be employed in hospital, private and district work distinct, with those engaged in nursing the poor living in a separate home. Private patients were only accepted after the need for hospital and district nurses had been met.

However, it was not inevitable that associations could not successfully combine district and private duty work, the latter helping to pay for the former, although private duty did often take precedence. It seems to have been most successful where nurses were employed for *either* private duty *or* district work, rather than where private duty nurses gave gratuitous service when between private cases.

When in between cases, however, private duty nurses would sometimes be sent to nurse patients on the districts, even where associations did employ separate

nurses for private and district work. In Derby, for instance, the superintendent would send private duty nurses to sit with a patient being cared for by a wife or mother in order to give her a rest.

The Acland Home employed an average of 26 private duty nurses in any one year, but only one district nurse. These staff nurses were sometimes employed in occasional visiting of district cases, which it was felt added to their experience and gave them something to do while awaiting private cases. They were also at times given the entire charge of a severe case, including one nurse who in 1882 was sent for three months exclusively to nurse a woman with cancer, which suggests that they may have been better qualified than the district nurse.

The Worcester Institute was the only association which actually increased its work with the sick poor, and this was probably because of its organisation. The Institute was formed to nurse private patients, but encouraged the formation of local associations in the city and the county in order to raise the funds necessary to pay for a district nurse, who would be supplied by the Institute. The Institute often supplied nurses to districts affiliated to the Rural Nursing Association in the county, as well. It charged £26 *per annum* for an 'ordinary nurse' and £28 for one who was 'fully trained'. These fees caused some disquiet, however, because district nurses in the city lived in the nurses' home, whereas in rural districts the local association would have the expense of their board and lodging in addition.

Patients who could not afford a private nurse, but who were too well off to receive a district nurse, often described as 'of modest means', were supplied with nurses at reduced rates by some associations. The Stratford Association

did state as an objective, to superintend the sick poor gratuitously, supply skilled nurses at modest means for moderate charge and send nurses to private families at fixed rates, but many associations gave reduced rates on a more *ad hoc* basis. In Stratford and the Acland Home the lady superintendent arranged reduced rates, whereas the committee of St. John's House decided eligibility.

The 1882 annual report of the Acland Home stated:

> A large amount of truly charitable work has been done .... in the supply of nurses on lower terms to patients whose resources were severely strained by the other expenses of illness. Great caution and discretion are needed in the administration of relief of this kind, but ....the lady superintendent has brought sound judgement to the task.[48]

In Stratford the lady superintendent visited the sick poor, often arranging for night nurses in severe cases, and dispensed food. Although private duty nurses were expected to help in the home when not out on cases, running the home and visiting the poor was often too much for the superintendent, and visits to the poor suffered. In 1890, therefore, one nurse was designated to remain in the home to assist her. In 1896 a nurse was employed exclusively to visit the poor and an appeal was launched to pay for her, but as it only raised £11-16/- her services were discontinued after six months, and the resident nurse devoted a greater part of her time to the poor.

In Derby three nurses were reserved for working with the sick poor, but sometimes one had to be withdrawn to attend urgent private cases. "In all such instances the money earned by the nurse has been considered in a manner due to the poor, and has been expended on the gratuitous district work."[49]

All associations required written reports on the conduct of the nurses from the private patients, some of which resulted in disciplinary action or dismissal, but most reports from district patients appear to be unsolicited. The superintendent at Derby did go to the houses of patients and enquire about the nurses' conduct, but she never entered. In Liverpool a lady inspector went round to enquire into the general conduct and efficiency of the nurses.

Private duty nurses nursed one patient at a time and usually lived in the patient's home, whereas most district nurses visited many cases at one time. Twining, in 1896, objected to this difference between the way that district nurses and private duty nurses worked, although she did admit that most homes of the poor would not accommodate a live-in nurse, nor would most families be able to afford to feed her. Reference has been made above to the great number of visits carried out by some district nurses, so that the numbers required to nurse one patient at a time, including night duty, would be great.[50]

Some associations supervised rather than actually provided nursing to the poor, so would show families how to carry out a doctor's instructions or apply dressings, others like the Ranyard Mission and the Metropolitan Association gave nursing care and 'put the room in nursing order'. Miss Lees reported that in Derby only the "better working class", whom she thought capable of paying a contribution, received nursing care, the very poor only receiving nourishment.[51] She cited the example of a man with an abscess on his hand which was neither cleaned nor dressed, only food was given to him. This distinction is not made in either the objectives or the annual reports of the Derby Association.

An exception to the usual arrangement was the Staffordshire Institution for Nurses where the nurses did not take a district, but were provided gratuitously on the same basis as private patients - one case at a time. Needless to say not much gratuitous work could be undertaken.[52]

Some associations tried to define the nurse's position in the household, for example the Stratford Association stated that the nurse should be "regarded and treated as a trusty upper servant",[53] and in Derbyshire the nurses were expected, when not engaged in the sick room, "to make themselves generally useful" in homes with no servants.[54] Private duty nurses would have been, at least before the end of the century, a lower social class than that of their patients, akin to governess or companion in status, but district nurses were the same or a higher class, which made the relationship different. There was also no monetary exchange between district nursing associations and patients.

Where district nurses were employed from the ranks of educated women, such as the Metropolitan Association, nothing other than nursing care was given to patients, which included putting the room 'in nursing order', differentiating the role from that of lower class nurses and philanthropic endeavour. When professionalisation was attempted towards the end of the century, this was by district nursing associations. Was this because private duty nursing was linked to domestic service, and would therefore not be amenable to professionalisation? Yet unless it was seen as a profession it would not attract the middle class women who were thought necessary for raising the status of nursing. A woman used to employing domestic servants was unlikely to choose an occupation where she became one. This question will be addressed in chapter 8.

Accommodation

It was not just the tasks of district nursing, and the division of district from private duty work which was used to attempt to define district nursing. Where district nurses should live was bound up in the social relations of the occupation and, as will be demonstrated in this section, this was used to create a specific image of nursing. Florence Nightingale believed that nurses should live together in a nurses' home. Although her rationale was concerned with practical reasons, "[t]his obviates all questions as to whether the District Nurse may (a) take lodgers; (b) if a widow with children have her children living with her. Both are objectionable",[55] it was also easier to supervise nurses living in a communal home, and to ensure that they observed the rules of the association. It conformed to the cloistered existence of the Sisterhoods, emphasising obedience and nursing as a vocation, and minimising the opportunity for nurses to become deflected from their calling. Indeed, Nightingale had written of hospital nurses entering the Nightingale school that "they should live in a home fit to form their moral life and discipline" (quoted by Cook 1914:430)

This model was adopted by the Liverpool School in 1860, after Rathbone took advice from Nightingale, and many associations followed suit, especially those like the Metropolitan Association, which were influenced by Nightingale. Rathbone felt that the standard of nursing improved once nurses were living together in a common home, and it also provided *esprit de corps* and mutual support.[56] Despite the fact that the nurses were now part of the official economy, the legacy of the Sisterhoods persisted.

The Acland and the Stratford Homes housed patients as well as nurses. The Acland Home provided beds as many people who needed nursing, such as

students, did not have suitable accommodation, and the Stratford Home was also a convalescent home for women and children.

The fourth condition of affiliation to the Queen's Institute stated that in large towns the nurses would reside in homes and be under the charge of a trained superintendent approved by the council.[57]

There were, however, exceptions to this and some nurses did live in their own homes. Nurses of the East London Nursing Society lived in lodgings, paid for by the parishes in which they worked. To provide a home would have been too expensive for the committee, and the Queen's Institute accepted this on its affiliation in 1891. However, the committee was written to regarding the exceptional nature of the affiliation, and the hope was expressed that with more funds at their disposal they would adopt a better system. The Leicester Institute, however, was refused affiliation in 1891. It did have a nurses' home, but only for private nurses, the district nurses living in or near to their districts. It was not affiliated until 1909 when it built a new nurses' home for all the nurses. Having no nurses' home was often combined with having no trained superintendent, as was the case in Leicester, which was against another of the Queen's Institute conditions of affiliation, and so refusal of affiliation was commonly on these two counts.[58]

Derby was visited by Florence Lees in 1875, who reported the lady superintendent as saying she regretted that the nurses did not all live in a common home, rather than in their own as there "is no comparison between the work of the nurses who looked upon their profession as their one object in life and the nurses whose hearts were bound up in their family life, rejoicing when their appointed nursing duty being over they can return to their children"[59] The

annual report of the Derbyshire Association for that year issued a rebuttal saying:

> There is a great mistake in this assumption. The theory looks good upon paper, but it is not borne out by experience. The fact is our district nurses do generally live in their own homes, and some of them have children and family cares not a few. It is a special characteristic of our work throughout that it is natural, and we regard it as a special excellence that women such as we have just described can and do give complete satisfaction and exhibit a zeal and oftentimes a self denial not to be surpassed by any.[60]

Ranyard nurses, too, lived in their own homes, and while the decision on accommodation was for many associations a financial one, for Ranyard it was philosophical, and was related to her belief, discussed in chapter 6, that only women from the same class as the patients would be accepted by the poor. From their inception biblewomen were expected to live in the district allocated to them, and to use their position within the community to observe and influence the population. This policy was continued with the nurses, as it was felt that the biblewomen provided an "already proved foundation", and that the nurses would be as close to their patients as they would in hospital.[61]

In 1888 Mrs Selfe Leonard, Ranyard's successor, criticised the fact that nurses from the Metropolitan Association lived in a central home, and were, therefore, sent all over the areas of London covered by it. Indeed, Mary Cadbury wrote to her mother about her Christmas Day 1879 visits:

> As the morning went on the fog thickened so dreadfully that I didn't know how to get up to Highbury but I started in good time, could find no bus and walked asking the way many times for there was no seeing and I knew only the

> principal streets and soon got wrong or out of them but people were very kind.[62]

Cottage Benefit Nursing Association nurses lived in their own homes between cases, as this allowed widows and others who did not want to break up their homes to become nurses. As Broadwood commented "If a woman is not to be trusted to live in a home or lodgings of her own, she is certainly unfitted to go as a nurse into the houses of others."[63]

Where nurses lived, then, was more than personal choice or convenience, it was, for many associations a matter of policy. For those adopting a nurses' home, this was consistent with the cloistered conditions of the sisterhoods and nurses in the voluntary hospitals. It reduced the independence of the nurses, in both their personal and working life, and gave the impression of chaste and virtuous womanhood, as opposed to the widely held view of nurses as inebriate and promiscuous. This was intended to enhance the image of nursing for those educated women whom many of the elite in nursing were trying to encourage into the occupation. It also helped to form a distinct occupational identity, but one that was allied to hospital nursing. Like the governess or companion, the only other occupations thought suitable for middle class women before the growth of clerical work, the nurse was to be cocooned within a supervised home. By entering the world of work nurses were moving outside their expected role, and the nurses' home reproduced the environment of a Victorian household in terms of placing constraints on the autonomy of women.

Where nurses lived in their own homes the reasons were often financial, Mrs Selfe Leonard reporting that Ranyard nurses were the cheapest in London "it costs a well known nursing society as much to provide six Nurses and a

Superintendent as it would cost us to supply fourteen Nurses and a Superintendent."[64]

For the Ranyard Mission this was secondary, the rationale being more concerned with who should provide nursing to the poor, how they could best carry it out, and who could most readily influence their way of life. In this Ranyard was most influenced by district visiting societies, and as she was not attempting to create an image of nursing that would appeal to middle class recruits, nurses living in or near their districts would seem most appropriate for her purpose.

Funding

Thus far this chapter has concentrated on the work of the nurses themselves and the social relationships of the occupation. The 'work' of district nursing associations also included raising the finance needed, and this was carried out by volunteer labour. When attempting to link fundraising to volunteer labour, the criteria of lack of market exchange becomes tenuous. Individuals involved in fundraising may not be involved in market exchange, but the fruits of their labour are, for example the employment of nurses, or the provision of food or relief (Maxwell 1998). I think that in this instance the defining feature of volunteer labour is that market exchange did not result in personal gain.

As previously stated, the main reason for the precedence of private work over district nursing was financial, and most associations expressed regret that it was necessary. The development of a waged form of work from what had been carried out informally meant that funding was a major area of concern for all district nursing societies, and it demonstrates the precarious nature of voluntary

welfare. Future finance was always uncertain, encouraging the tendency to react to presenting problems, rather than to develop long term strategies. Associations were reliant on donations and subscriptions, plus any money that was received from the income of private nurses. There were also *ad hoc* receipts of offertories, and later in the century donations from Saturday and Sunday Funds, although in Stratford these seem to have been used for the upkeep of the home, rather than the gratuitous work.

Publications like the Missing Link openly canvassed donations and presented examples of the successful work of the organisation in order to attract funds. Evangelical charities put the emphasis on successful conversions, others concentrating on patient recovery or a change from slovenly to hygienic domestic habits. Stories of the successful recovery of patients described as 'contrary to all expectation', or 'given up as hopeless by doctors', were commonly used. An example from a Liverpool nurse tells of a girl with consumption:

> This girl was under two medical men who said it was a decided case of consumption (father paralytic, mother keeps a mangle). She was so weak she had to be carried, and was refused admission to hospital as too far gone. .... in the course of one month the girl was able to come to my house and is now quite recovered.[65]

Liverpool appeared to have fewer financial problems than a lot of other associations, despite the fact that district patients took precedence over private, and this may have been because of the parochial nature of the organisation. The central society paid the nurses' wages and in each district, which adhered as far as possible to ecclesiastical boundaries, funds for lodgings, medicines, food and

comforts were raised locally. This was usually done by the lady superintendent or the local clergy and/or their wives. In 1864 this averaged £80 per district *per annum*. Local congregations also paid for two district nurses in Derby parishes, and the Derbyshire Association felt that without more like these the work with the poor could not be maintained. By 1889 a small charge for appliances was having to be made because of financial difficulties.

The funds of the Sisterhoods were boosted by the sums brought into the Institutions by the Sisters themselves, and in the case of St. John's House by the provision of nurses for a number of hospitals. As more hospitals started their own training schools, the gratuitous work by St. John's House at first increased because more nurses were available, but later reduced considerably. Many organisations relied on regular subscriptions from benefactors and the death of one or more could drastically reduce income. As the Stratford Association delicately put it "Several old and liberal supporters no longer contribute."[66] Local newspapers were also used to canvass additional funds, and the Stratford upon Avon Herald was very supportive to the Stratford Home, issuing some colourful appeals:

> In the homes of the working poor times of sickness are times of straitened means and the sick have to be dependent in most cases on the unskilled attendance of the young of the household and the occasional attendance of neighbours. Devoted and unselfish as this attendance is, it is of necessity insufficient, and year after year the sick in such households pass beyond recovery for the want of the skilled watchfulness and counsel of the trained nurses. This is a matter to which the nursing home directs special attention, and the result hitherto has been most gratifying. The value of this work, indeed, may be gathered from the testimony of the patients, who declare that it is the best way

> of helping poor people that could possibly be conceived.[67]

The lady superintendent, Miss Minet, also used the letters' page of the paper to appeal for funds for surgical appliances, food, clothing, and coal for outdoor relief in cases of sickness and extreme distress.

Some associations found that confusion over the different branches of their work led to a paucity of donations. The Acland Home found that fund-raising for the gratuitous work was affected by its having a self supporting home for its in-patients and private patients. People did not perceive the district work as different, and needing support. The Derby Association, too, found that some people felt that by donating to it they were paying to train nurses for the rich, even though that side of the work was self supporting. Conversely, the Stratford Home found funds easier to raise for its convalescent home than for its gratuitous work.

The *Missing Link* gave details of the Ranyard Mission's constant funding difficulties. It was thought that starting a nursing mission would enlist fresh support, but there was always the worry that it would, in fact, draw funds away from the biblewomen. A separate fund for the nursing mission was commenced, but by 1871 nurses were being sent to the country, where the district requesting them would pay the Mission £20, as the funding was not sufficient to keep them in London. By 1872 the list of monthly subscriptions had fallen, and an appeal was made in the Missing Link. £250 was needed monthly for the work of the nurses to continue. Throughout 1873 and 74 finances were difficult, and in February 1875 it was reported that few districts were raising their own funds and most were reliant on the mission's general fund. The editor

encouraged more lady superintendents to raise funds locally. Although 32 nurses were supported by ladies, who paid for their employment and provided their supplies, only 61 out of 185 districts were fully self supporting. Regular subscriptions were difficult to induce, but donations for individuals were often sent following descriptions of their cases in the *Missing Link*. For example a water bed was provided for a woman described as deformed and distorted with a spinal complaint and rheumatism. The editor commented that the cases described were only representative, there were many more like them and so regular, rather than one off, donations were needed.

Despite the prestigious nature of its council, and its high profile compared to other associations, the finances of the Metropolitan Association were equally unpredictable, after an initial influx of money. In 1878 when the entire local committee at Holloway resigned, the matter was regarded as very serious because it had guaranteed half the expenses of the Northern Home.[68] On its inception it had been anticipated that a capital sum of £20,000 and an income of £5,000 per annum to establish a training school and to found the district home would be raised. This was not the case, however, a fact that the council attributed to "the severe depression in trade which has prevailed since the association was founded."[69] It was decided that in future homes could only be founded where local committees could carry out the work and raise the necessary funds to do so. The central council would continue to finance the central home as a home for district nurses and as a nursing school for training and providing nurses and superintendents for any part of England. A scheme for patient payment was also formulated.

The notion of provident associations was raised in chapter 5, and this was one way of reducing the unpredictability of funding. Bertha Broadwood felt that most cottagers would never ask for a nurse if she was provided free, and also that a free nurse would affect the trade of existing local nurses. The Cottage Benefit Nursing Association had a sliding scale of fees, ranging from labourers at 2 shillings annual subscription, and 2 shillings per week when receiving a nurse, to 10 shillings annual subscription, and 10 shillings per week for nursing for gentry. Records for 1887 show that all classes of people used the nurses, mainly for confinements. In Daventry a payment of 2d per month (or 4d for families) provided nursing, and some associations, for example Stockton, collected payment by a deduction from wages. Other associations mixed provident with gratuitous work for the poor (Hurry 1898). This form of district nursing was, however, more a feature of the twentieth century.

Like many philanthropic societies the finances of most district nursing associations were precarious. The volunteer labour involved in financing and fundraising was crucial to their existence and continuation. Those raising the funds could also control how they were spent, and on whom, and contributions were frequently given with the expectation that help for the poor was conditional on them conforming to a particular moral culture. This will be addressed in the next section.

District nurses as agents of social control

Throughout this thesis the controlling function of district nursing has been alluded to, without the nature of social control actually being addressed. Mention has been made of the imposition of middle class values by the teaching

of cleanliness, self help and thrift, and the use of nurses for surveillance purposes during epidemics. The poor, especially women, were often viewed as ignorant of child care, and cleanliness and hygiene, but constraints on their ability to change the conditions in which they lived were rarely addressed. Social control was not just a matter of nurses controlling patients' lives but also of ensuring that female nurses conformed to the image of piety and subservience. Examples have been given within this chapter whereby living in nurses' homes, training, and supervision by ladies were all ways of controlling the lives of nurses, and ensuring the perpetuation of the image required to enhance the status of nursing. Florence Lees advised nurses that they must know how to observe and report correctly, and apply provisionally suitable treatment until the medical man arrives. They should also obey written orders. This suggests elements of autonomy and control, and its relevance to the professionalising process of district nurses will be discussed in chapter 8.

The whole notion of social control is somewhat problematic, in that what has been recorded and retained has tended to be documented by those controlling, rather than those controlled, an example of the selectivity discussed in chapter 2. This has led in some instances to translate "archival silence into historical passivity" (Jones 1977:163), with a consequent bias towards the controlling actions of the dominant class, with no cognisance taken of attempts to resist or to formulate alternative actions. Donajgrodski (1977) argues that social control is not always overt or recognised, and although controlling the poor may well have been the aim of some philanthropists, many had a consuming passion for their cause. This is consistent with Freidson's (1978) description of the subjective economy as being carried out for love or glory, and Summers'

(1979) argument that philanthropy was for many women the engagement of the self.

It is, however, important to separate what was intended from what was actually achieved. It may have been the intention of those setting up ragged schools, district visiting or nursing societies to control behaviour (Thompson 1981), but without direct or proxy information on the extent to which the poor resisted the attempts, or were discriminating in what they accepted, then all conclusions as to the results of intervention must be treated with caution. For example, Ranyard wrote in 1862 that "the helping into work is the greatest possible benefit we can bestow upon the people, and cultivating them into the habits that fit them for work, of cleanliness, order and sobriety."[70] The feelings of the poor about this is normally recorded as gratitude. Indeed, Rathbone commented in 1865 that instruction by a district nurse, coming as a natural and necessary part of her duty to the sick was not felt as interference, raised no opposition, and its authority was enforced by the visible and immediate improvement effected by the nurse in the health and comfort of the patient.[71] However, a Mrs Layton wrote of her own experiences at the hands of philanthropists:

> I had attended Mothers' Meetings, where ladies came and lectured on the domestic affairs in the workers' homes that it was impossible for them to understand. I have boiled over many times at some of the things I have been obliged to listen to, without the chance of asking a question.
> (Davies 1977:40)

It is also possible that working class families, particularly those of skilled artisans, actually wanted to emulate middle class behaviour as a means of self

improvement, and Hunt (1981) refers to the natural tendency to imitate the fashions of those immediately above in the social hierarchy.[72] Musgrove (1979:77) concurs, stating that the 'labour aristocracy' adopted the ideals of respectability and self help in the context of their social and economic lives, rather than as an imposition by the bourgeoisie.

It must also be borne in mind that the idea of what Thompson (1981:190) calls "embourgeoisement by social control" ignores the autonomous development of working class culture, and the extent to which people were selective in what they accepted from philanthropic agencies. One problem, as argued above, is that although records of charitable organisations have been preserved, the views of their clients have not.

Similar difficulties arise when considering the role of mass education in social control. When studying working class education in isolation, controlling elements seem conspicuous, but comparison is rarely made with middle and upper class schooling, where repression was the norm (Musgrove 1979:72). "The cleaning up of England's upper class in the reformed Public Schools was one of the most ruthless sanitary operations of Victorian England". The education available to the rich was a far more effective method of transmitting a coherent set of values and beliefs than the late nineteenth century compulsory education of the poor. Abercrombie and Turner (1978:164) make a similar point in arguing that "the dominant ideology is best seen as securing the coherence of the dominant class." This was necessary for the conservation of private property, and the educational system of the elite exposed them to the "apparatus of ideological distribution" far more than it did the poor.

Having accepted these limitations, there is ample evidence of attempts by the middle and upper classes[73] to control and/or constrain the behaviour of elements within the labouring and poor sections of the population that were perceived as a potential threat. Examples have been given of the differential care given to poor patients and paying patients, a controlling element being present in the care of the former. Lees wrote that the district nurse:

> should consider it one of her most important duties to inculcate cleanliness, whether it be cleanliness of air, person or surroundings. Her aim must be not only to aid in curing disease and alleviating pain, but also through the illness of one member of a family to gain an influence for good so as to raise the whole family.[74]

The influx of labour into the expanding cities engendered a heightened sense of class division, and the opportunity for mass disruption and social unrest. Thoughts of the French Revolution inciting similar revolutionary tactics in Britain produced fears about the control of an unstable and geographically mobile population. As the rich lost their direct influence it was thought that the poor would be incited by their disreputable elements (Dennis 1984). Sieveking, for example, viewed at least some of the poor as a threat, and saw Poor Law Unions as "a temporary expedient for averting the threatened eruption of violence and destruction."[75] Nightingale called the district nurse "the great civiliser of the poor"[76], and would seem to regard district nursing as providing one response to this perceived threat. The Annual General Meeting of the Worcester Institute in 1892 stated that their nurses exercised " a grand civilising influence over the poor."[77]

Social unrest varied in intensity from decade to decade, and from place to place. The 1830 and 1840s, for example, were times of relative agitation. Birmingham, with its small units of production was less militant than single industry towns. General movement and social change interacted with local conditions, and economic and social structures, such as the opportunity for the workforce to mobilise (Morris 1993, leading to a variety and complexity of responses.

Davidoff at al (1976:142) argue that historians have overlooked the zealousness with which the Regency and Victorian upper and middle classes attempted "to recreate wherever possible conditions favourable to a stable deference to a traditional authority." Because this was most easily secured in small social structures, they sought to create within the cities, districts which would be analogous to rural, pre-industrial communities.

Rack (1973:358) states that this stemmed from an idea of:

> A semi-mythical harmony of interest and sense of mutual obligation between the different ranks of society, and the social and religious control exercised (so it was said) in rural communities.

The idea of a 'golden age' before the industrial revolution, when there were no social divisions, and rich and poor existed in harmony was widely held, and it was thought that by modifying the characteristics of rural communities to the conditions of urban living, social and religious problems could be solved.

A capitalist mode of production had led to less personal employer/employee relationships, with mediation by managers and supervisors, which made it more difficult for employers to control the conduct of people's lives. As Gerard (1987) notes, paternalism is most effective when conducted face to face. From

the 1820s district visiting by the rich (or their agents) to the poor developed rapidly, as rich and poor became increasingly spatially distanced, and many schemes became large scale, quite sophisticated organisations. District visiting allowed middle and upper class women to observe and influence the lives of the poor. There had always been a tradition of casual visiting to the poor, but what the charitable societies did was to systematise this (Prochaska 1980).

Donajgrodski (1977) notes that as the century progressed, for reasons discussed above, social control processes became less paternalistic and more bureaucratised. District nursing, whether by 'native agents' or by educated ladies can be seen as part of this process of bureaucratisation, mediating between those wishing to influence the lives of the poor, and the poor themselves.

The middle class household, and middle class moral culture were held to exemplify that to which the poor should aspire, but as Abercrombie and Turner (1978) point out this was not the ideology of a dominant class, as described in most literature on social control, but of an *ascendant* class.

The Rural Nursing Association suggested to ladies living in the country

> who have taste and leisure to learn nursing, that such knowledge should be turned to excellent account in the houses of their poorer neighbours .... and would be an invaluable influence for promoting better modes of life among our rural population.[78]

Nightingale, too, acknowledged the role of the district nurse in 'improving' the way of life of the poor:

> The nurse also teaches the family health and disease preventing ways by showing them her own in their homes. The drinking father, the

> driven, dawdling dirty mother come also under her influence. They are ashamed to let her see themselves and their room again in such a state (this is not a vision but a fact). Their improvement becomes contagious to their neighbours.[79]

There was for the poor the *quid pro quo* of a high standard of nursing care. Lees stated that "no nurse should take up district work unless she feels that to serve the poor is her vocation. .... every poor person should be as well and as tenderly nursed as if he (*sic*) were the highest in the land"[80]

Conclusion

This chapter has utilised empirical data to demonstrate the way in which district nursing developed following the emergence of the early Sisterhoods. The over-riding characteristic was heterogeneity. District nursing associations usually emerged as a response to a locally perceived need, and as such were either organised specifically around that need, or reflected the views of some or all of the initiators on what constituted an appropriate service for the sick poor. Diversity was apparent in the type of woman thought suitable to become a nurse, the actual work carried out, in the amount of training considered necessary for her to do the work, how she was supervised and where she lived. There was also a problematic relationship with private duty nurses. Much of this was also true of hospital nursing and midwifery. Yet these occupations were unified while district nursing was not.[81]

It has been argued that training was used to construct nursing in a specific way, subservient to medicine. It was used to eradicate competition by demarcation, which reduced the ability of district nurses to identify a body of work over

which jurisdiction could be claimed. This was further compounded by the fact that associations acted independently in deciding what nurses should do. No one group had the size or the power to attempt to define district nursing by exclusion, nor would it seem the inclination, until the end of the century.

Lay superintendence also helped to construct district nursing in a certain way, the legitimacy of the Lady Superintendent's role being maintained by social class relationships. In the Sisterhoods the ability to bring an income into the organisation conferred a superior position in the hierarchy. Class relationships also facilitated the controlling elements of secular district nursing, allowing middle class values to be imposed on the poor. Much has been made in this thesis of the existing gender division of labour, based on task distribution, while leaving unchallenged patriarchal relationships. An analogy can be made here with the social class division of labour. This was also based around task distribution, power relationships based on social class being uncritically accepted. It was the lady superintendents who defined what it was appropriate for nurses to do, and who controlled the nurses' behaviour.

This chapter has shown how work tasks and organisation emerged and developed, and therefore theories of professionalisation have been less useful than a consideration of what constitutes work, and when that work becomes an occupation. The different tasks involved in the developing occupation of district nursing proved problematic for defining a discrete body of work, and the existence of official and volunteer labour raises questions about the status of the work of each. The existence of different kinds of domiciliary nurse carrying out various tasks, and being part of diverse hierarchical structures made it difficult to claim jurisdiction over a discrete area of work as a single

occupational body. Moreover, the existence of the other groups made it difficult for any one group to professionalise using exclusionary tactics. No one group had sufficient power over the others to initiate demarcatory strategies. These issues became crucial factors in later attempts at professionalisation, and will be explored in the next chapter.

Notes

[1] Bodleian Acland Papers 1562 d8 Acland H W (1856) 'Memoir on the cholera epidemic at Oxford in the year 1854 with considerations suggested by the epidemic':98

[2] ibid:99

[3] ibid:101

[4] ibid:139

[5] Bodleian Acland Papers e2 'Fever in agricultural districts: a report on cases in the parish of Great Horwood in the county of Buckinghamshire' 1858

[6] LMA H1/ST/NC18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London:46

[7] ibid:53

[8] Son of Henry Wentworth Acland, and like his father a correspondent of Nightingale's.

[9] Bodleian Acland papers d54

[10] Henceforth called the Leicester Institute.

[11] Henceforth called the Worcester Institute.

[12] The implications of training and character for the professionalisation of district nursing will be addressed in chapter 8

[13] LMA H1/ST/NC18/33/2 First quarterly report of the superintendent general:2-3

[14] LMA H1/ST/NC7/3 Nightingale F (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':10

[15] H1/ST/NTS/Y16/1/100a Twelve lectures were delivered by each of these doctors from London hospitals, and this move towards a more science based training will be discussed further in chapter 8.

[16] LMA H1/ST/SJ/A33/31 Annual report :4

[17] LMA H1/ST/NC/V1/69 Charles Langton was on the committee of the Liverpool School, and Henry Bonham-Carter was Secretary of the Nightingale Fund. He was a nephew of Nightingale's and one of her most enduring correspondents. He was later prominent on the councils of both the Metropolitan Association and the Queen's Institute.

[18] LMA A/RNY110 Missing Link 1874:228

[19] ibid:229

[20] The Missing Link was alluding to the Metropolitan Association, whose origins will be discussed at length in chapter 8.

[21] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town':44

[22] LMA H1/ST/SJ/A19/2 Lady Superintendent's report 17.11.1849

[23] Many doctors were quite ambivalent about trained nurses, however, and using contemporary accounts from The Lancet, Moore (1988) demonstrates that there was a feeling that nurses should be given just enough training to obey instructions, but that anything beyond that was dangerous, and would make nurses unsafe.

[24] LMA H1/ST/NC7/3 Nightingale F (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':12

[25] LMA A/RNY110 Missing Link 1874:228

[26] Derby Studies Centre A610.73 Annual report 1869-70

[27] Bodleian Acland Papers GA Oxon 8^0 560 Annual report 1880:13

[28] LMA H1/ST/NC18/28/35 Bertha Broadwood to Henry Bonham-Carter 17.06.1893

[29] Bodleian 15192 e 8 Broadwood B (1887) 'Nurses for sick country folk' :8

[30] ibid:9

[31] Bodleian 211 e 555 'Elizabeth Malleson 1828-1916':155

[32] The difference in approach of Malleson and Broadwood may be explained by their backgrounds. Although both were from wealthy families, Broadwood lived in the country all her life, and her ideas grew from her observations of the rural poor. Malleson, on the other hand, was an educated woman who lived for most of her life in London, and was a friend of early feminists, such as Barbara Leigh-Smith (a cousin of Nightingale). Her ideas for district nursing reflected her more general thinking on women's position in Victorian society.

[33] Trained supervisors as a strategy in creating a profession for educated women will be discussed in chapter 8.

[34] LMA A/RNY110 Missing Link 1874:228

[35] Shakespeare Birthday Trust 87.3 Annual report 1872:4

[36] Provident societies collected regular sums from members, who were then entitled to some form of benefit. In the case of medical benefits this was care given free or at reduced rates. Provident societies conformed to the dominant ethic of self reliance.

[37] LMA H1/ST/NC18/33/2 First quarterly report of the superintendent general:4

[38] This will be discussed further in a subsequent section.

[39] Bodleian Acland Papers GA Oxon 8^{0} 560 Annual report 1898:7-8

[40] Derby studies centre A610.73 Annual report 1869/70:6

[41] LMA H1/ST/NC18/33/7/1 Annual report 1881:19. This example highlights the problem for a professionalising occupation of the existence of a untrained body of workers, and will be discussed further in chapter 8.

[42] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in large town'1865:46-7

[43] The relationship between district nurses and handywomen, if one existed, will not be discussed here, as annual reports and records of associations barely mention them beyond vague references to untrained nurses, although the implications of the persistence of untrained nurses for professionalisation will be considered in chapter 8.

[44] Lees' use of the subjective 'declined' here probably demonstrates her missionary zeal towards district nursing as an occupation more fitting to middle class women than private duty nursing, which will be discussed further in chapter 8.

[45] As noted in chapter 6 annual reports, including those of St. John's House stated that nurses went willingly to the poor. In 1888 it was stated that many nurses who left at the end of their term with St John's subsequently took up district nursing.

[46] Wellcome SA/QNI/F1/4 Florence Nightingale to William Rathbone

[47] Wellcome SA/QNI/A1 Memo from William Rathbone

[48] Bodlcian Acland Papers GA Oxon 8^0 560 Annual report 1882:5

[49] Derby Studies Centre A610.73 Annual report 1871-2:5

[50] Wellcome SA/QNI/N.6/5 Twining L (1896) 'District nurses in the homes of the poor'

[51] LMA H1/ST/NC18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London:46

[52] LMA H1/ST/NC18/11/44 Sarah Harding to Henry Bonham-Carter

[53] Shakespeare Birthday Trust 87.3 Annual report 1872:10

[54] Derby Studies Centre A610.73 Annual report 1865:5

[55] LMA H1/ST/NC7/3 Nightingale F (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':12

[56] Bodleian 15192 e 17 Rathbone W (1905) 'The history and progress of district nursing'

[57] ibid

[58] The issue of trained superintendence will be discussed in chapter 8.

[59] LMA H1/ST/NC15 13 a & b Report of the sub-committee of reference and enquiry on district nurses in London:48

[60] Derby Studies Centre A610.73 Annual report 1875-6

[61] LMA A/RNY104 Missing Link 1868:132

[62] LMA H1/ST/NTS/Y16/1/102 The Cadbury Letters

[63] Bodleian 15192 e 8 Broadwood B (1887) 'Nurses for sick country folk':36

[64] LMA A/RNY/127 Bible Work at Home and Abroad 1892:189

[65] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town':47

[66] Shakespeare Birthday Trust 87.3 Annual report 1889

[67] Stratford upon Avon Herald 16.02.1883:5

[68] Guildhall 14618 Annual report 1878. Problems did not abate, however, and in 1880 Florence Lees wrote to Florence Nightingale that the nurses at Holloway were very difficult, and refused to start work punctually. Their nursing was not considered to be of a good standard, for example Miss Lees reported that the remains of a poultice were not cleaned off before the next was applied.

[69] Guildhall 14618 Annual report 1880:6

[70] LMA A/RNY/98 1862 'The book and its missions':325

[71] BL 7686 aaa 33 Rathbone W (1865) 'The organisation of nursing in a large town'

[72] There is some tentative evidence for this in that skilled artisans often moved out of the big towns to the periphery of the middle class suburbs (See for example Cannadine 1993)

[73] The aristocracy and landowning classes

[74] Bodleian 15192 e16 Dacre Craven Mrs (1889) 'A guide to district nurses':2

[75] BL 8275 cc 23 Sieveking E (1849) 'The training institutions for nurses and the workhouses: an attempt to solve one of the problems of the present day':10

[76] Wellcome SA/QNI/F1/7 letter to the Duke of Westminster 16.12.1896

[77] Berrow's Worcester Journal 05.03.1892

[78] Wellcome SA/QNI/W1/2 Rural Nursing Association

[79] Bodleian 15192 e 17 Rathbone W (1905)'The history and progress of district nursing': xiv-xv

[80] Bodleian 15192 e 16 Dacre Craven Mrs (1889) 'A guide to district nurses'

[81] This raises an interesting question about why there was a difference between hospital nurses, midwives and domiciliary nurses in the degree of homogeneity, but one which is beyond the scope of this thesis.

CHAPTER 8

Professionalising strategies in district nursing

Introduction

By the 1870s there were a number of district nursing associations in England, some of which also provided private duty and hospital nursing. As has been demonstrated throughout this thesis there was no uniformity between them in terms of the tasks undertaken, training given or supervision. Chapter 7 has described how training was used as a demarcationary tactic in order to control and restrain domiciliary nurses' autonomy. Towards the end of the century credentialist tactics were used by some as an exclusionary strategy in an attempt to raise the status of nursing to that of a profession, and the form of nurse training was moving to a more scientific model. Could this be interpreted as a professional project, more particularly a female professional project? Was this move facilitated by the fact that doctors no longer saw district nurses as competition, and a threat? There is evidence to suggest that this was the case. Fox (1996), citing editorials in the *British Medical Journal*, states that doctors were on the whole supportive of district nursing, especially that of the Queen's Institute. This is consistent with the testimonials received from doctors by the Ranyard Mission and the Metropolitan Association, some of which have been quoted in chapter 7. Cottage nurses were also viewed favourably by doctors, and the opinion of one, as quoted by Broadwood, may give an indication of the change in attitude:

> I am glad .... to say that the nurses are all of them, I believe without exception, ready and

> willing to take their place as assistants to the doctor, to carry out his directions rather than their own notions of what should be done .... And yet act with fairly good discretion and judgement when there seems need to make any change in the doctor's absence.[1]

Once a training had been established which inculcated in nurses ideas of obedience and servility, the perceived threat from them was perhaps diminished, and doctors actually found that nurses could be useful as assistants, carrying out instructions, and relieving doctors of some of their more mundane tasks. A more scientific training, far from assisting nurses to compete with doctors, could now be seen as something that would assist doctors. This likely change in perception by doctors coincided with ideas of others who wished to create in district nursing an occupation that would be attractive to educated women.[2]

This chapter will consider the strategies adopted by district nursing associations who wished to create a profession of educated women, in particular who initiated such strategies, and whose interests they served. It will move away from a focus on concepts of work, and what constitutes an occupation to consider theories of professionalisation, in particular jurisdiction and social closure. Attempts to attain uniformity and professional status were a feature of district nursing, but not of private duty nursing and the reasons for this will be considered. I specifically wish to consider whether diversity among district nursing associations was too great to achieve the stated aim of the Metropolitan Association and the Queen's Institute - for district nursing to become a profession which would attract educated women.

Before attempting to answer these questions, I wish to consider the usefulness for this thesis of the abundant contemporary correspondence on the foundation of both the Metropolitan Association and the Queen's Institute. Much of the correspondence between Florence Nightingale and Florence Lees, and Nightingale and Henry Bonham Carter suggests that there were many conflicts and difficult personalities, and it is hard at this juncture to assess different agendas involved. For example, Lees' quite obsequious letters to Nightingale would strongly suggest that she found her a very supportive friend. Indeed, Lees would not make a decision concerning her role at the Metropolitan Association without consulting Nightingale.[3] Nightingale's correspondence with Bonham Carter and with Rathbone, however, was often highly critical of Lees.[4] In view of this, and because it is not the personalities that I am interested in, rather the occupational politics that they espoused (Witz 1992), I shall restrict the use of such correspondence to instances where I feel that it sheds light on the development of district nursing.

The Metropolitan and National Association for Providing Trained Nurses for the Sick Poor

Beginning in 1874 attempts were made to create a single trained district nursing force for the whole country, the rationale being that there were no trained nurses for the sick poor in their own homes. This ignored the many associations that were by this time being formed in various parts of the country, whether by accident or design is a matter of conjecture, but it may well have been because of the type of working women many of them employed. A public meeting was held in London regarding the provision of trained nurses for the

If I may as your pupil and delegate come to you almost daily for instructions (I know how great a tax this will be on your tax and strength but who else has such powers of organisation - or can give such clear, wise and yet womanly counsel). And before undertaking this work may I ask your counsel and advice upon the minor details of furnishing the future 'home', dress of the District Nurses etc.[7]

A national survey was undertaken by Lees, and the findings reflect her ideas about what district nursing should be[8], rather than provide an overview of the current state of district nursing. Not all associations co-operated with Lees, for example both Devonshire Square and the North London Deaconesses refused to let her visit patients with their nurses.

The report of the sub-committee included Lees' survey which found existing provision to be patchy and of varying standard, with five general criticisms:

1. Too much relief and too little nursing given
2. Too little control and direction leading to neglect
3. Too little supervision over allocation of cases
4. Too little communication with doctors
5. Too little instruction given to family in regard to care - for example, ventilation, cleanliness and disinfection

Lees wrote to Nightingale in January 1875 "I was, moreover, so utterly disheartened by the whole thing. I actually never came across <u>one</u> case in which I could say that the District Nurse <u>nursed</u> the patient."[9]

It was felt by Lees that the root of these problems lay in the type of women who became district nurses, and the amount of training they were given. Liverpool's nurses were mainly from the "superior servant class",[10] and

sick poor on June 25th, attended by, among others, Sir Henry Acland, Sieveking and Spottiswode.[5] Acland proposed setting up a sub-committee to inquire into existing district nursing provision in London and the provinces, the original idea being to initiate a national organisation, with a sub-committee in each county. The previous day Nightingale had written to Acland that information should be obtained on what district nurses were employed in London and by whom. Then a small scale operation on the lines of Liverpool should be started, training district nurses in hospitals under a trained lady superintendent. As early as August 1873 she had refused to become a Vice President of the proposed Association, but said she would advise Miss Lees and others, although not publicly.[6]

Through her correspondence with Bonham-Carter, Rathbone, Acland, and Lees, Nightingale exerted influence behind the scenes on the Metropolitan Association's organisation. Baly (1987) states that Nightingale made the pellets and Rathbone fired the shots.

An undated letter from Lees in 1874, informing Nightingale of her acceptance of the post of Superintendent General of the Metropolitan Association demonstrates her deference to Nightingale:

> I said I should be glad to accept this work for 2 years. But dearest friend and "Mistress" it must indeed be under you that I undertake it. I must report to you almost daily and learn from you how I am to meet and surmount the difficulties that must surround a work of this kind at the beginning. Up till the day before yesterday I had been wicked enough to hope that "the big scheme" might never be carried out - it seemed to me so impossible to obtain from the public the large sums required .... Will you therefore be patient with me if I venture to ask you once more whether indeed I am capable of doing this work?

associations such as Derbyshire and Stratford employed 'respectable' women recommended by subscribers or the clergy. Lees, however, did not consider that women of this type would have sufficient influence to persuade the poor to alter the way they lived. The report also recognised a need for the education of private duty nurses, but did not include them, although stating that the poor were actually better off for good nursing because hospitals had improved so much. It cited Nightingale who said that the rich as well as the poor die from the lack of good nursing.[11]

Initially, Lees, more than either Nightingale or Rathbone, was resolute in her determination to make district nursing the preserve of educated women, and she persuaded them to her cause. In 1874 Nightingale wrote "On the whole it would seem to require a higher class of woman to be District Nurse than even to be Hospital Nurse."[12] The phrase 'higher class of woman' was later used by Lees to describe the type of nurses she required for the Metropolitan Association.

The report of the sub-committee recommended that district nurses should have:

- a more complete and elaborate training
- a higher standard of general education, a more cultivated intelligence
- a superior social status, because she has more influence in making authority natural and in reconciling others to subordination and obedience

Running through the report is Lees' conviction regarding the need to find suitable occupations for educated women (Baly 1987). Indeed, one of the objects of the association was "to raise by all means in its power the standard of nursing and the social position of nurses."[13] She wrote in her first quarterly report as Superintendent General:

> I give it as my unhesitating conviction that by limiting this work to well trained and well qualified gentlewomen, you will create such a class of nurse for the poor as no country has yet known or been able to produce.[14]

Here, Lees (and others who wanted to make nursing suitable for educated, middle class women) had three problems. Firstly nursing's link with domestic service hardly made it a candidate to be considered a profession. It has been noted in chapter 7, that Lees regretted that domiciliary nursing associations which attempted to combine district and private work 'declined' into private nursing associations, demonstrating her belief that district nursing was more appropriate than either private duty or hospital nursing for educated women. Secondly there was nothing in the work itself to justify the term 'profession' (Moore 1988). Thirdly, credentialism could not be forced onto other associations, or onto nurses working independently. All it could do was to demarcate and distance Metropolitan Association trained nurses. These problems will now be addressed in turn.

The link with domestic service was mainly, though not entirely, through hospital and private duty nursing. District nurses were usually of a higher class than their patients and therefore their work could not be controlled by patient wishes. The nursing association, not the client, set the agenda and decided on appropriate tasks. Freidson (1994) has noted that where the consumers of an occupation's service are large in number and heterogeneous, the occupation can more easily organise itself for its own ends. This was true of the patients of district nurses. By restricting its operation to district nursing, the Metropolitan Association could distance itself and its nurses from domestic service. It could

emphasise vocation and altruistic service as being its defining features. There was the added advantage that trained district nurses worked for associations, which facilitated a collective strategy, whereas private duty nurses were often isolated practitioners.[15] These demarcatory tactics were not enough, however, because even within district nursing there were many untrained, and what Lees saw as insufficiently trained, nurses for trained district nurses to gain jurisdiction over an area of work, and an occupational identity. Indeed, in some areas, especially more rural ones, untrained nurses were actually preferred, as they were cheaper, easier to control, and more acceptable to patients. There was, moreover, no control over the availability and use of handywomen, who would carry out many of the same functions as district nurses - and without moralising.

This leads to the second problem of being accepted as a profession, when the content of the work itself continued to be carried out in the informal economy. One of the ways in which Lees sought to distance trained nurses from untrained was in the primacy awarded to caring for the patient's surroundings. She saw the trained nurse as having three main functions -

> A nurse is first to nurse.
> Secondly to nurse the room as well as the patient
> - to put the room into nursing order. That is, to
> make the room such as a patient *can* recover in;
> to bring care and cleanliness into it, and to teach
> the inmates to keep up that care and cleanliness
> Thirdly to bring such sanitary defects as produce
> sickness and death, and which can only be
> remedied by the public, to the notice of the
> public officer whom it concerns.[16]

It was the second and third of these functions that Lees saw as differentiating trained from untrained nurses, functions which could only be carried out by a higher class of nurse. In the first annual report she stated from her survey:

> And here as a nurse I ought to observe that the placing and keeping a room in proper 'nursing order' has almost as much to do with a patient's recovery as the nursing care bestowed upon him personally. .... In all the various District Nursing institutions the rule exists, that the Nurses are to enforce cleanliness, fresh air etc., or to withdraw their assistance; but whenever the nurses were of an inferior class, in not one home of the very poor class, in any town or city, have I found this rule really enforced, and indeed rarely even named to the patient's friends.[17]

The idea of 'nursing the room', and the sanitary ideal, were taken from Nightingale, who saw them as the most important function of the nurse, and one where the nurse was infinitely more expert than doctors. She wrote to Lady Roseberry, a member of the council of the Queen's Institute, in 1888:

> The nursing of the sick poor at home is the highest branch of nursing, for the district nurse has no hospital helps but few. She must make the poor sick room a place where the sick poor can recover.
> She must first be a nurse but she must also nurse the room. That is an essential part of her duties - in cleanliness, in ventilation, in removing all sorts of foulness. And she must have the skilful tact and kindness to induce, to teach the friends how to do all this .... she must be a sanitary missionary, not an almsgiver.[18]

The essentially domestic tasks of nursing, then, were redefined as scientific by the medicalisation of sanitation and hygiene, which formed the basis of district nurse training. This did not, however, constitute a discrete body of knowledge,

as others, notably sanitary inspectors, were developing a similar knowledge base.

By employing educated women, and giving them a longer training, which encompassed theory as well as practical subjects, it was believed that nursing would become an accepted occupation for middle and upper class women, which would enable it to lay claims to professional status.[19] Rafferty (1996) also points to the change in nurse training away from the focus on the domestic and 'training for obedience' to a professional model based on science. Medicine was looked to for the content of the new training, as can be seen from Mary Cadbury's description of her classes at the Metropolitan Association, reported in chapter 7. As the Draft Report stated:

> To give nursing the social rank and standing that would make it a profession fit for women of cultivation a more comprehensive education and training would be necessary. And this would secure to its members the social position and material rewards that belong and are generally given to those who combine a scientific education with a useful calling.[20]

It was recognised that many women were unsupported and were unqualified to earn their own living, and the number of occupations open to middle class women was limited.

The report recognised the potential value of nursing in this regard:

> There are grave objections to women entering the medical profession, but who would object to making *nursing* a profession? It is closely allied with the medical profession, equally honourable, useful and if they are properly qualified, perhaps hardly less scientific.[21]

The impetus for professionalisation started with male dominated committees and the reasons for this need to be explored. Circumstantial evidence that the nurses themselves were not highly visible in professional projects can be deduced from Abel-Smith's assessment of the number of nurses employed as private duty nurses at the turn of the century. Out of a total nursing population of *circa* 69,200, well over half worked in the homes of patients, the majority as private duty nurses (Abel-Smith 1960). Comfortable living and working conditions, and higher rates of pay would seem to have been of more importance to nurses themselves than status, as private duty nurses were generally equated with higher domestic service. Hughes has been cited in chapter 3 as noting that occupations vary greatly in the degree of autonomy in determining their self identity, and district nursing had little influence over its early development. The influence of Nightingale and Lees cannot be discounted, but we need to look beyond the views of individuals and consider occupation as a social activity, the social and economic circumstances surrounding the carrying out of the tasks being central to explaining them. One answer can then be postulated by looking again at the third of Lee's requirements 'reconciling others to obedience and authority'. Here professionalising strategies can be seen to be bound up with strategies of social control.

Two examples from the report demonstrate the way in which this could occur.

First, on the type of woman most suited to district nursing:

> She should be a lady of education and breeding, as well as a nurse of the highest order, having received the superior professional training and instruction of which we have already spoken, and competent therefore to direct and instruct the

ordinary nurses, as well as able to secure their deference and obedience. It is obvious that such a class of superior nurses has yet to be created .... The professional spirit which is never wanting in those who have given themselves up to a career and been thoroughly educated for it would ensure their intolerance of neglect and slovenliness in nursing[22]

Secondly, on the subject of nursing order:

> May I also add that none but a Nurse of the 'highest class of women' could ever have sufficient moral influence over the uneducated masses of the poor, more particularly of the pauper class, to enforce such nursing order being kept.

Members of the committee echoed these sentiments, for example this report of

Dr Cheadle at the 1891 Annual General Meeting:

> He wished to place special emphasis upon the value of having *gentlewomen* by birth and education as Nurses for the sick poor, with the tact discretion and good breeding required them to exercise a good moral influence over their patients so as not only to nurse them back to health but to raise them and leave them better in other ways.[23]

So in order to control and influence both existing nurses, with their varied

training and none, and also the lives of the poor, women who were used to controlling others (i.e. servants) were thought most suitable. It is often repeated that only educated women of a higher social class than ordinary nurses would have the skills to achieve this.

> Women of a higher class, from the very nature of their education and surroundings from infancy, acquire a love and respect for cleanliness to which a lower class of women are strangers.[24]

But this type of woman would only be induced into an occupation with some social standing, and so it was necessary to exclude those women who would prevent this. Once again, a more elaborate training was thought necessary in order to achieve this:

> The better and more thorough the training given, the higher the character and standing of the profession; the higher its character and standing, the better the quality of the raw material that comes into the trainer's hands.[25]

Better training, then, would have a spiral effect, encouraging more educated women into the occupation, and simultaneously excluding those women of the servant class who had traditionally gone into nursing. This was considered especially important for women from whom superintendents were to be drawn, and this will be returned to below.

In summary, a dual closure strategy was attempted by the use of inclusionary tactics aimed at using a male medical model of education in order to raise the status of district nursing, while exerting exclusionary pressure downwards against working class women.

Despite the efforts of the committee of the Metropolitan Association, the third problem, that of credentialism not being adopted by other district nursing associations and independent nurses remained. Handywomen, cottage nurses, and families continued to work with the sick poor, with many associations, especially in rural districts, employing nurses with little or no training. All education could do was to demarcate and distance Metropolitan Association trained nurses, not define a distinct occupation. Despite the certainty of Lees, there was also no general agreement regarding the type of woman most suitable

to become a district nurse. So although Rathbone, writing to the trustees of the Queen's Institute in 1887, declared that:

> There is no doubt that ladies make generally the best District Nurses, provided they are sensible and devoted to their work. Not only do they require less looking after, but they are, we find, most ready to perform even the most repulsive services for the patients. and more influential in inducing poor families to follow their teaching and example.[26]

the following year Mrs Selfe Leonard wrote of the value of respectable women:

> Such duties [going out in all weathers, climbing steep stairs, carrying heavy burdens] must of necessity require greater strength and more enduring physical energy than are usually possessed by the young lady who has led a sheltered and protected life. Attractive pictures are often painted of the value and beauty of the Lady Nurse in contrast to her humbler sister, but while acknowledging the valuable work done by some of this class, we cannot but believe that the woman who is brought up to hard work is, on the whole, the most acceptable person to her patient.[27]

There were, however, other strategies used to distinguish the trained nurse from the untrained, both of which have been discussed in a different context in chapters 5 and 7. Here I wish to consider them as tactics aimed at defining district nursing.

Firstly, the whole question of relief, not just monetary, but also in the form of district visiting or sitting with the sick had been a matter of controversy, and something that associations had differing views over, but for Nightingale and Lees these duties formed no part of a nurse's function. Lees wrote that the giving of relief took the nurse away from nursing duties, because it was the

easiest and quickest of functions. It was necessary, then, to separate the nurse from the reliever. It was decided that the distribution of medical comforts should not be under the control of the nurse but of the lady superintendent "as the guardian and often the provider of the funds provided for that purpose .... with the advice of the medical man to assign what is needed."[28] Lees was quite determined that Metropolitan Association nurses should give nothing to patients beyond actual nursing care. A task was shed that was not viewed as skilled, demarcating an area of work that could be seen as defining professional district nursing. It created an occupational boundary which distinguished not only the trained from the untrained nurse, but also professional from philanthropic endeavour.

The second tactic concerned trained superintendence and supervision. This was a continual problem and will be raised again in the following section on the Queen's Institute, but my concern here is to consider the specific issue of the supervision of Metropolitan Association nurses. Lees was adamant that no trained nurse could be supervised by an untrained lady superintendent unschooled in the work of district nursing. She saw this as a crucial factor in the relief giving of some associations. It was felt that only trained superintendents would be competent to keep the standards of the nurses at the required level, and would be less tolerant of slovenliness and neglect. There was also the unspoken problem that untrained superintendents would have hindered district nursing from being accepted as a profession. Claims of the need for trained, educated women to be district nurses would seem unsustainable if the untrained were considered knowledgeable enough to supervise these trained nurses. So in splitting the role of reliever from that of

superintendent, and making the latter a trained role, a formal occupation evolved from work carried out in the subjective economy. Advancing Prochaska's (1980) argument that philanthropic work paved the way for women's acceptance as paid officials, it is my contention that in order for this paid occupation to develop, it may have been necessary for it to emerge in the subjective economy in the first instance. It was only when membership of the official economy became acceptable for middle class women that the shift could occur.[29] This new occupation served the needs of those seeking a suitable occupation for educated women.

It was originally intended that the Metropolitan Association should found its own hospital training school, along the lines of Liverpool, but this was never achieved, and it either sent nurses for hospital training, or recruited trained nurses for district training. A central home was established in Bloomsbury, where the nurses lived and were trained, and from where they were sent out on cases. Again, Lees written reports on the nurses differs from her private correspondence. In her first quarterly report she stated that the first nurses were five:

> thoroughly trained and well qualified gentlewomen of the class recommended by Miss Nightingale .... they have nursed all classes of disease and in some of the worst of the worst homes of the poor, and in every house they have entered, fresh air, order and cleanliness have been introduced.[30]

In August 1875 she had, however, written to Nightingale that she had difficulty in finding the nurses enough cases to nurse. "I have implored the dispensary doctors and the clergy surrounding us to send us "cases"."[31]

More district homes were opened in London, but due to funding shortages, by 1881 Bloomsbury was the only home financed centrally, all others being under local control.

In 1882 a small charge began to be made to patients, but financial difficulties continued until the foundation of the Queen's Institute.

Apart from Lees' strong conviction that district nurses should be educated ladies, there were also more pragmatic reasons concerned with recruitment. She wrote in her first quarterly report:

> Will the committee permit me to remind them that it is yearly becoming more difficult to obtain the common class of women in anything like sufficient numbers for the requirement of our hospitals, and even more difficult, if not impossible to obtain good servants. Why then, should we persuade this class to take up work for which hundreds of better educated women desiring employment, and with no means of obtaining it, are better fitted. ....
> At present the only 'Nursing' open to a lady is to take the superintendence of Nurses, either as Sister of a ward or as Matron of a hospital and yet nine out of ten women are unfit for superintendence, although they may be admirable nurses, yet they cannot earn their living as simple hospital or private nurses without losing caste among their own kith and kin.[32]

This quotation also confirms Lees' view of private nursing as being inferior to district nursing. Nightingale, too, wrote to Rathbone in 1887 that ladies were more fitted to district than private nursing.[33] When people such as Lees and

Nightingale wrote about nursing being a suitable occupation for educated women, they were only considering hospital superintendence or district nursing, where, as argued earlier, a distance from domestic service could be demonstrated. Domestic tasks which had not been redefined as scientific remained the domain of working class nurses, especially in hospitals.

This section has demonstrated that the Metropolitan Association attempted a number of dual closure strategies. These were attempted by exerting inclusionary pressure upwards by the use of credentials, and exclusionary pressure against working class nurses. Credentialism was attempted by introducing a longer and more scientific training than what had gone before, based on a medical model. Demarcationary tactics were demonstrated by shedding what were seen as non-nursing tasks, losing the link with domestic service, and adopting an area of work (nursing the room, and the teaching of sanitary laws) which was perceived as defining professional nursing. Yet despite these efforts, few of the strategies were adopted by other associations and district nursing remained a diverse occupation with no agreed training, and no clear boundaries or functions. Did this, then, provide the impetus for the Queen's Institute?

Queen Victoria's Jubilee Institute for Nurses[34]

In 1887, the year of Queen Victoria's Diamond Jubilee, the women of England organised a fundraising. After buying jewellery and a monument to Prince Albert, £70,000 was left in the fund, which the Queen wished to use to support nursing. She appointed the Duke of Westminster, Sir James Paget and Sir Rutherford Alcock as trustees, all of whom were on the council of the

Metropolitan Association. This had not seen its work expand beyond London, because of the shortage of funds discussed above. The previous year, when the idea of a jubilee fund being used for nursing was first announced, Rathbone wrote to Nightingale urging that they make their ideas known early. He included his ideas for a scheme, which were influenced by her ideas on nursing.[35]

After consultation with Nightingale, and using his experience of Liverpool and the Metropolitan Association, Rathbone wrote to the trustees on August 18th 1887, to suggest how the funds should be utilised for district nursing. His ideas have more in common with the philosophy of the Metropolitan Association than that of Liverpool:

> I may assume that the object of the Queen and her advisors will be that the fund shall be so used as -
>
> 1. To maintain a high standard of nursing, not only professional (by insisting on each nurse having at least a year's regular training in a hospital) but also moral. This is especially necessary in those who lead so independent a life as that of nurses among the poor. A properly trained nurse should not only nurse and show the family how to nurse the sick, but put, and show the people how to put, the sick room into fit condition for the patient, and generally to keep their homes in a healthy condition; also how to apply to sanitary authorities to do what individuals cannot do. Above all she should keep in mind the importance of not pauperising the family by charitable relief, but rather raising their position by teaching them self-help and healthy habits and ways.
>
> Experience shows the more thorough the training and the work is, the more it extends and becomes permanent by enlisting interest, and securing confidence and help, personal and pecuniary.
>
> 2. To attract the best style of woman from all classes - the higher, the middle, the lower middle and the upper servant class. At present the

> supply of ladies and others who wish to be nurses is in excess, but the number of those suitable, especially for superintendence is insufficient.[36]

Rathbone, like Nightingale, saw a role for women from many socio-economic groups in district nursing, and here, as has been stated above, they were in conflict with Lees. All three, however, thought that superintendents should be drawn from the upper classes, for the reasons given in chapter 7, and that potential district nursing superintendents should receive training only from Bloomsbury .

Rathbone and others were adamant that the Jubilee Fund should only be used for nursing the sick poor at home, and not the rich, the rationale being provided by the committee in a note to the Queen, which stated that the poor were increasingly well nursed in all types of hospital, and the rich, being able to pay had created a need which had been responded to by private enterprise. This runs contrary to what the report of the sub-committee of reference and enquiry on district nurses in London had stated on the subject of private nurses, but by now the suitability of educated middle class nurses for the sick poor was probably felt to have been established. Since Florence Lees was on the committee, and brought to it her ideas of the class of woman suitable to be a district nurse the argument was most certainly advanced.

The committee wrote:

> There is one class of poor that remains neglected when sick, because they are unwilling or unable to enter hospital or have an inadmissible illness. This particularly applies to women and children. With few exceptions in disconnected districts, there is no adequate provision for trained nurses to visit. In the few areas of the cities and large

> population centres where there are associations they do good work but are inadequate. So a more powerful and influential organisation is needed to fill the wide spaces wholly unprovided for.[37]

It was proposed that rather than going to the expense of establishing a training school for nurses, the Metropolitan Association would train nurses for the Queen's Institute, which would then deploy them to affiliated associations. The Metropolitan Association agreed in principle, but was concerned that the standards that it had established should be maintained by affiliating organisations. There were also questions concerning the relationship between the Queen's Institute and local associations and committees. It was generally thought that most existing associations would not fulfil the criteria for affiliation, and that new ones would need to be created.[38] The Metropolitan Association had failed in its attempt to make district nursing an occupation of fully trained middle and upper class women, and in fact had never moved beyond London. As has been demonstrated in chapter 7, it had little influence on the length of training of other associations, and the occupation was as diverse as ever. The Queen's Institute can be interpreted then as an attempt to impose the standards and philosophy of the Metropolitan Association across the country, adding a further exclusionary strategy of affiliation.

It was suggested that the Metropolitan Association should be used as the principal training school for Queen's nurses, using its organisation to establish other centres. All nurses, in order to be eligible for inclusion on the roll of the Queen's Institute were to have at least one year's hospital training and six months training in district nursing. In addition three months training in

maternity nursing was required for rural districts. Pressure was put on the council, especially by Lees to raise the length of hospital training to two years, but it remained at one year and in 1897 Rathbone wrote to Peile[39] that until the supply of nurses was equal to demand, Queen's could not demand more than one year's training. It was, however, raised to two years in 1898.

On successful completion of training nurses would be placed on the roll, and issued with a badge, which constituted an emblem of distinction from other district nurses. This was to be returned if the nurse stopped working with the sick poor, or worked for a non-affiliated association, and no nurse not working for an affiliated association could be recommended for the roll. By this exclusionary strategy, as more associations affiliated the Queen's Institute would gradually come to control district nursing, and entry to it. Peile insisted that the object of affiliation was "to try and raise the standard of excellence in the nursing work; and therefore whether an association can be affiliated to the Institute must depend on whether the arrangements as regards the work fulfil our conditions."[40]

There were, however, compromises made as many very experienced district nurses did not have the required training. Where an association which had a hospital trained nurse without district training working as a superintendent wished to affiliate, a two month training was offered at Bloomsbury. A nurse without district training could be placed on the roll after two years experience with an affiliated association. During the first year the names submitted for consideration for the roll included "many who have been for some time engaged in Nursing and who are in all respects qualified to be Queen's Nurses."[41]

By 1889 nurses were being trained by the Metropolitan Association for the Queen's Institute in addition to those being trained for employment by the association and its branches, and in 1892 the work of starting new district nursing homes was taken over by Queen's. The object of establishing a training school for nurses, which had been an intention from the inception of the Metropolitan Association, was abandoned, as most hospitals had by now started their own, and replaced with the objective of supplying district nurses primarily to the Queen's Institute and its affiliated associations.[42] In 1893 only Bloomsbury and Liverpool were considered to provide sufficient training for nurses to be added to the roll.

It was recognised early on that compromises would have to be made if the Institute was to succeed. There were by the 1890s many district nursing associations over the country, some with committees made up of powerful members of their local communities, and not all were willing to affiliate to an association which dictated how they should run their affairs. On December 2nd 1895 Rathbone wrote to Peile that insisting on the same high standards for the rest of the country as London would result in associations not attempting to improve, and taking cheap, wholly untrained nurses. In the least populous and least wealthy parts of the country he felt that there was not the need for lady nurses, and there was not always the means to pay for them. Here, Rathbone is echoing the feelings of Broadwood on the different needs of rural districts. The Queen's Institute had no right or power "to enforce upon these places a rate of payment or maintenance beyond what would be sufficient to secure respectably trained nurses of the upper servant and lower middle class order."[43] Rathbone thought that it would gradually be possible to persuade places of the value of a

superior class of nurse, but if Queen's was to be made truly national, the conditions of affiliation could not be too strict to allow places to meet them. As will become apparent, managing the tension between the ideal and the pragmatic was not always easy.

This attitude brought Rathbone and others into conflict with the Metropolitan Association, which refused to lower its standards (as it perceived them) in order to take women of a lower class. Because of this the formulation of a new agreement was proposed. Regards training the affiliation sub-committee came to the conclusion that:

> it is most important that the Metropolitan and National Nursing Association and Kindred Homes should continue to occupy themselves mainly with the training of probationers of the educated gentlewoman class suitable for superintendents and senior nurses and generally for nursing the metropolis.[44]

The Council of the Institute endorsed this as it felt that London was "wealthy enough to be able and so far has been found willing to pay for this superior class of work."[45]

Worcester was felt to be particularly fitted to taking probationers for rural districts and country towns, and Liverpool those from the upper servant class.

The affiliation sub-committee acted in a gatekeeping role, the president and honorary secretary deciding which of the associations that had applied for affiliation should be put on the general inspector's list for inspection. The sub-committee received her reports and recommended affiliation, rejection or affiliation subject to conditions. It also attempted to control the nurses employed by affiliated associations, by requiring them to notify it of all new

nurses that they employed in order that they could be checked to ensure that they were up to the required standard. This was not accepted by the council and was replaced with a request for associations' annual reports, including details of engagement and qualifications of all nurses, to be sent to the Institute. So control of entry was mainly via entry to the roll, and the issuing of a badge, with disaffiliation the only sanction against those associations whose nurses were not considered suitable. Since this did not prevent the association from continuing to function, it was a fairly weak sanction, the use of which could have been more detrimental to the Institute than to the association concerned. In 1898, for example, the Worcester Institute was disaffiliated for failing to meet the conditions of affiliation. At the annual general meeting it was stated that the Queen's Institute had insisted on certain conditions that Worcester felt unable to conform to, but not what these were. The Worcester Institute continued to operate and re-affiliated early in this century.

Florence Lees, who was a member of the council, continued to press for the employment of trained ladies as district nurses, and wrote to Nightingale

> I daresay you have heard of my emphatic protest against the appointment of a lady as inspector of the QVI who has never had any experience of district nursing and sending her to inspect the works of nurses who have been engaged in it for years .... hospital nursing is quite distinct from district nursing .... it would be heartbreaking to see district nursing lowered instead of raised to a higher level.[46]

She also monitored the probationers sent to the Metropolitan Association by the Queen's Institute and at a council meeting in 1891 "stated from her own knowledge that some of the probationers lately sent to be trained as Queen's

nurses were not of the gentlewomen class and she considered that the standard was being lowered instead of being raised."[47] A letter was also read from the Honorary Secretary of the Metropolitan Association (Mr Dacre Craven)[48] with reference to two probationers who were not of the same class as those who were ordinarily received at Bloomsbury.

In 1894 Dacre Craven wrote to Bonham Carter objecting to the appointment of a lady superintendent to an association affiliated to the Queen's Institute who had had only "an insight" into the work "In some cases we have yielded in others declined",[49] suggesting that the compromises made by the Queen's Institute were quite fortuitous. As can be seen, Lees and Dacre Craven were reluctant to accept the training of women other than ladies as Queen's nurses, but only had any real influence over the Metropolitan Association. They used this to instigate a demarcatory tactic *within* the Institute by insisting that only ladies be trained at Bloomsbury, and that these be the only nurses considered for the role of superintendent.

A major obstacle to the Queen's Institute's attempts at professionalising strategies was the existence, not only of other associations of district nurses, but also of other systems of affiliation, two of which were discussed in chapter 7, the training and way of working of some of these being contrary to that of Queen's.

In 1890 a rural district sub-committee was set up to inquire into the current state of nursing in rural districts, and the best way of dealing with it within the objects of the Institute. Not surprisingly a questionnaire survey revealed great diversity in the work of the nursing associations, and the training of the nurses. A large number of associations confined their work strictly to gratuitous

nursing of the sick poor. Few had a superintendent or matron, and only three of these were trained in district nursing. Opinions were divided over whether nurses should be ladies or women of a lower social class. Most 'ladies' had had hospital training, the rest had training from lying-in hospitals. At a meeting between the Queen's Institute and a deputation form the Rural Nursing Association, which had been formed to promote trained nursing and midwifery in country districts, the latter expressed itself happy to modify its conditions to fit into the requirements of Queen's, and to consider modifications that might be necessary for the special requirements of district nursing in different localities. Despite this, there were problems, often alluded to by Rathbone, concerning the affordability of trained nurses in some districts, and a fear that associations would continue to employ untrained nurses, and not even attempt to meet the Queen's Institute standards. There was also a worry about Queen's nurses themselves not having enough work to keep them occupied, and therefore not staying in rural areas. For these reasons Queen's compromised with the Rural Nursing Association over the continued employment of village nurses providing they did not displace a Queen's nurse. It could not afford to alienate all non-urban associations, which employed large number of nurses, and whose existence could have hampered changes in training and hindered the dissemination of Queen's Institute philosophy. A clear distinction could be made between district nurses and village nurses, and the work they undertook. Maternity nursing was a large part of village nursing, but not undertaken by Queen's nurses. Village nurses therefore posed little threat to the image that the Queen's Institute was attempting to establish, or to its attempts to become accepted as a profession, based on a scientific model of nursing the sick poor.

By now it was lesser trained nurses from the working class employed by some urban associations who would appear to have been perceived as the major obstacle to raising the status of district nursing.

The same degree of compromise was not reached with the County Associations at the turn of the century, possibly because many of the county presidents were not convinced of the need for trained nurses or a uniform service. The County Associations believed that the Queen's Institute did not understand the peculiar conditions of country work. Negotiations between Rathbone and the Presidents highlight the differences in perception of what district nursing should be. Rathbone, while agreeing that there may be districts where there is so little to do that a Queen's nurse would not stay and a village nurse would suffice, nevertheless thought that the Institute should not co-operate in providing trained nurses (other than village nurses) with a lower standard than its own. However, one of the county presidents said that she did not care for hospital training and would sooner have a nurses without, another was indifferent to district training and appointed a superintendent with only hospital training. This again demonstrates that many areas did not think Queen's nurses appropriate for their specific conditions.

The County Associations proposed affiliation of its members employing an intermediate class of nurse with less than Queen's training, and putting on the roll experienced district nurses without training, but the Queen's Institute felt that this would displace Queen's nurses and substitute inferior but cheaper ones, and as mentioned above, there would be the temptation to save money.[50] Fox (1996) comments on the lack of demand for expensive Queen's nurses as a continuing problem for the Queen's Institute.

County associations like Northumberland and Lincolnshire were particularly antagonistic at having their associations controlled by the Institute, and Rathbone accused them of directing their efforts to keeping alive old slipshod methods that were pre-Nightingale reforms.

Apart from training, supervision was also a contentious issue. Hampshire, Lincolnshire and Northumberland wanted the Queen's nurses placed under a county superintendent along with the village nurses, but Cornwall was against this, as the superintendent would not have time to supervise village nurses and inspect Queen's nurses. This illustrates the lack of conformity even within associations. Rathbone stated that Queen's nurses must be inspected by a paid official of the Institute, and concurred with Cornwall by adding that Queen's nurses may not want to be inspected by an inspector of village nurses, and in turn the village nurses may not get enough supervision.

It was agreed that local associations which met Queen's Institute conditions for affiliation could affiliate to both Queen's and the County Association. The Queen's Institute would inspect all nurses on the roll, but the nurses would work under the direction of the local committee. Where a County Association found Queen's Institute terms unacceptable it would disaffiliate, although local associations within that county could remain affiliated, if they met the conditions.

The conditions of affiliation were too high for many associations to meet, especially the length of training, trained supervision and the provision of a communal home, although this last was often waived where only one nurse was employed. Supervision by the Queen's Institute also meant a reduced role for lay committees, which would have paid for training and raised funds for the

nurse's employment. As noted in chapter 7, a lay committee, or its representative in the form of a lady superintendent, was often active in supervising the work of the district nurse, vetting her cases and organising her visits and receiving her reports. This subjective labour was an important organisational feature of many associations, which did not want to relinquish the responsibility while they were still expected to provide funding. The hierarchy between official and subjective labour, started by the Sisterhoods, and which Lees was attempting to overturn, proved very resistant. As stated in chapter 5, one of the advantages of philanthropic provision of social services was perceived as the ability of those paying to ensure that services or relief were going only to the deserving poor. Why should associations continue to finance a nurse over whom they had no control?

Peile in 1892 denied that Queen's Institute did take control away from local organisations, stating that "at first a good many associations held aloof because they thought that we wanted to interfere with the management of their work - they have since found out that we do nothing of the kind, and they have asked to be affiliated."[51] There are, however, examples from the inspectors reports that would suggest there was interference in the running of associations, such as a visit to Hulme and Stretford in 1893, where only one nurse was deemed eligible to be a Queen's nurse. "All the nurses are uneducated and of an inferior class." It was recommended that "two of the nurses should not be retained and a better educated and more refined class gradually got."[52]

The number of affiliation visits and the rate of affiliation in the 1890s would suggest that much scepticism remained concerning the Queen's Institute, and it was not just committees which had reservations. The superintendent of the

Coventry Association objected to becoming a Queen's nurse and neither she nor her nurses applied, even though this ran contrary to the wishes of the committee.[53] This case is documented as an inspection was requested by the committee, but what cannot be judged is how many other nurses refused to apply to be entered onto the roll, or why.

A Mr. Jackson (brother of Mrs de Zoete, who provided most of the income for the Walworth District Nursing Home) wrote to Bonham Carter on behalf of his sister who wished to know whether the Queen's Institute could be relied upon for its nurses and for the recommendation of the superintendent general, as she had heard more than once that the standard required for its nurses was not high.[54] Again it is not possible to judge how representative this comment was.

Conclusion

For most district nursing associations, including the Ranyard Mission, making district nursing a profession was not an objective. Many associations looked for character in terms of honesty, hard work and respectability, rather than education in their nurses. In Liverpool Rathbone employed the higher domestic servant class of women, but appears to have been converted later to the idea of educated ladies as district nurses, especially in London. This was probably due to the influence of Lees, who convinced him that ladies were less likely to resort to relief giving. His correspondence cited in chapter 5 would support this assertion. Many associations wanted a nurse who would work according to the wishes of the committee, rather than have her own ideas about how things should be done. It is therefore my contention that professionalisation was a minority interest.

The Metropolitan Association and the Queen's Institute attempted to demarcate their nurses from other district nurses, from other types of nurses, and from philanthropic effort by laying claim to a distinct area of work, based on the sanitary idea, and hygiene. They used credentialist tactics to control entry, by making the essentially domestic tasks of nursing scientific. The problem was that others, paid and unpaid could do the work, and did. The distinguishing features were that Queen's nurses should be well trained, give nursing only and no relief, be expert in sanitary laws and the teaching of them to the poor. They should only be supervised by a trained superintendent. Only educated ladies were deemed capable of performing all of these functions, and yet as we have seen in chapter 7, the diversity of functions meant there was no monopoly of tasks, and demarcatory tactics did not define clear boundaries between Queen's nurses and other district nurses. As Freidson (1994) points out it is difficult to sustain the claim to an exclusive right to perform a task when others can perform it. He argues that "to single out for emphasis concrete tasks by which encroachment can be unequivocally identified" (Freidson 1994:87) is important in negotiating market shelter. For professionalising district nurses hygiene and cleanliness, and the teaching of sanitary laws was what set them apart. Only trained nurses would have the knowledge of these, and only a lady would have the authority with the poor to persuade them to adopt new habits. She could also recognise and report to the public health officers any sanitary defect, and have her report taken seriously. Nightingale thought that trained nurses were the experts, and knew far more of this than doctors. She wrote to Acland in 1869:

> With two or three brilliant exceptions, "the doctors" are far behind a humble, experienced, observing matron in such matters as how disease is produced, "contagion" and the like. Poison a nurse with medical contagion theories and she will be ruined.[55]

The sanitary idea had the dual effect of controlling the poor and preventing contagion to the rich, and creating an area of work differentiated from other types of domiciliary nursing.

Even this did not create a distinct occupation with clear boundaries and discrete tasks, as other associations, notably Derbyshire, were interested in teaching sanitary laws and 'nursing the room'. There was also the problem that despite the efforts of the Metropolitan Association and the Queen's Institute, nurses continued to move between private and district work, and teaching of sanitary laws was not a feature of private work.

Of the associations discussed in this thesis, only Liverpool, the Metropolitan Association and Worcester had affiliated to Queen's by the end of the century. The Acland Home affiliated early in the twentieth century, but let the affiliation lapse.

It was not only the existence of non-Queen's nurses that caused problems for the exclusionary and demarcatory strategies of the Queen's Institute, but also the attitudes of many committees of district nursing associations regarding the supervision of nurses. A condition of affiliation was supervision by Queen's trained nurses or equivalent, and periodic inspection from the Queen's Institute. This would have reduced the authority of lay committees, and would have left them in a position of fundraisers, rather than organisers. Yet as seen in chapter 5, for many women philanthropic pursuit was a full time activity, the

main difference between many lady superintendents and the nurses being the pecuniary relationship to the association. While only the work of the nurses may be defined as constituting an occupation, the work of lady superintendents as part of the subjective economy, produced services of considerable use value. Now that paid occupations for middle class women were becoming acceptable in English society, the Queen's Institute was attempting to assert the superiority of the official over the subjective economy. This was a reversal of the situation started by the Sisterhoods, which had dominated for *circa* fifty years, and was still very influential.

Although Queen's did compromise on conditions of affiliation regarding length of training, many associations found the conditions too strict, and also not appropriate - for example, in rural areas. This inhibited moves to make district nursing a profession because the occupation remained diverse and unregulated. Exclusionary tactics could not be enforced, jurisdiction over a discrete set of tasks could not be claimed.

The tactics adopted by the Metropolitan Association and the Queen's Institute were not merely an example of an occupation acting in self interest, as a monopolistic interpretation would suggest. Exclusionary and demarcatory tactics and the attempted claim of jurisdiction were also part of a genuine desire to raise the standard of nursing and to improve sanitary conditions for the poor. Indeed, Florence Lees often spoke of district nurses as being in turn the teachers and the servants of the poor. By creating a false dichotomy between self interest and altruism, the symbiosis of these two concepts is obscured. As has been demonstrated throughout this thesis, occupations can, and often do, act with self interest and altruism simultaneously, both at the

organisational level of the occupational association and at the microscopic level of the practitioner. The interests of the occupation and the public interest can, and do, coincide (Saks 1995)

Diversity of working practices, and differences in philosophy between district nursing associations would appear too great for common ground to be achieved, so that no claim to jurisdiction over an area of work could be made. There was no consensus about the value of education and training or what defined district nursing. Vested interests of lay committees and the professionalisers of the Metropolitan Association and the Queen's Institute were in some instances diametrically opposed.

Could the Metropolitan Association and the Queen's Institute have been more successful in achieving their aim? It is doubtful, as Stacey (1988) has said about nursing reformers generally, whether much more could have been achieved in developing a female occupation within the constraints of Victorian ideas about the role of women, especially within the gender division of labour and exisitng medical demarcatory politics.

Can the professionalising strategy of the Metropolitan Association and the Queen's Institute be interpreted as a failed professional project? The outcome of a professional project is social mobility and market control, and neither of these was achieved. The status of district nursing and control of the market could not be advanced without the means of gaining a monopoly, yet the diversity of the occupation precluded this. Larson (1977) states that a project is collective, the motivation for the individual practitioner being fear of exclusion and the maintenance of social distance from the unqualified. The Metropolitan Association and the Queen's Institute did not constitute a collective, as most

district nursing associations did not attempt to meet their educational standards or conform to rules regarding supervision. The opportunity of employment with these associations meant that non-Queen's trained nurses did not fear exclusion if not included on the roll. Occupational closure was not, therefore, achieved.

Was this a female professional project? Witz (1992) describes female professional projects as not simply resistance to the demarcatory strategies of dominant groups, but attempts to consolidate their own position by exclusionary devices - dual closure. I have argued that district nursing did not resist demarcatory tactics from doctors, but accepted a gender division of labour based on task specialisation. It has also been identified that most district nurses themselves did not seem to view professionalisation as an issue, the impetus coming from mainly male councils of the Metropolitan Association and the Queen's Institute, together with a small elite group of women such as Florence Lees. Larson (1977) differentiates between the autonomous or heteronomous character of the means employed to achieve market control, and Hughes (1971) acknowledges that occupations vary greatly in the amount to which they become the master determinants of their social identity. District nurses themselves did not engage in professionalising projects, but could be viewed as the pawns in strategies devised by others.

Notes

[1] Bodleian 15192 e 8 Broadwood B (1887) 'Nurses for sick country folk'

[2] Doctors themselves may well have changed, training in hospitals with a reformed nursing staff may have made them more skilled at delegation, and more willing to do so.

[3] The advice given by Nightingale strongly affected the development of the association, and will be discussed within this chapter.

[4] See also Baly (1987)

[5] William Spottiswoode was the Queen's printer and member of the Council of the Nightingale Fund

[6] LMA H1/ST/NC18/75/3 Florence Nightingale to Robert Wigram 23rd August 1873

[7] LMA H1/ST/NC18/33/31

[8] Examples of this have been given during this thesis - for example, criticism of the Derbyshire Association for not having a nurses' home, of a number of associations for giving relief.

[9] BL add. ms. 47756

[10] Wellcome SA/QNI/A1 memo from William Rathbone to the trustees of the Queen's Institute:2

[11] LMA H1/ST/NC18/33/3 Draft report of reference and enquiry on district nurses in London

[12] LMA H1/ST/NC7/3 Nightingale F (1874) 'Suggestions for improvement of the nursing service of hospitals and on a method of training nurses for the sick poor':12

[13] LMA H1/ST/NCY/7a Objects of the Metropolitan Association

[14] LMA H1/ST/NC18/33/5 First quarterly report of the superintendent general 1875:14

[15] Comparison can be made here with the professionalisation of the medical profession, which was facilitated by a more collegiate approach, and a change in the relative social position of doctor and patient brought about by the growth in voluntary hospitals (Jewson 1976, Parry and Parry 1976). Rafferty (1996) has commented that very few comparisons have been made between the profesisonalising strategies of nurses and doctors, Whiggish histories of medicine emphasising the growth of science, and nursing history focusing on events, such as the Registration Act, 1919.

[16] LMA H1/ST/NCY/7a 1876 'On trained nurses for the sick poor':6. Although in published reports Lees continued to assert that only educated ladies would nurse the room and teach the

patient's family, in private correspondence she admitted that this was not always the case. In 1880 she wrote to Nightingale:

> of the best of these [hospital trained nurses] who have remained with us for one year of longer not one has ever taken kindly to "district rules" with what you have aptly termed "nursing the room" as well as nursing the patient. However "thorough" in surgical dressings or in carrying out medical treatments they always considered what we would term the first canon of nursing "the cleanliness of surroundings" as of quite secondary importance. (BL add ms 47756)

Those nurses who started as probationers with the Metropolitan Association learnt this while on trial before hospital training.

[17] LMA H1/ST/NC18/33/5 First Annual Report:15

[18] BL add ms 45809 fol66

[19] Chapter 7 has noted the importance given to character and practical ability in the training of district nurses. The developments reported here were seen as building on, rather than replacing, these.

[20] LMA H1/ST/NC18/33/3:9 Draft report of the sub committee of reference and enquiry on district nurses in London

[21] ibid

[22] ibid:43

[23] LMA H1/ST/NC18/33/7/1 Annual report 1891

[24] LMA H1/ST/NC18/33/5:14 Annual report 1878

[25] LMA H1/ST/NC18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London:28

[26] Wellcome SA/QNI/A1Memo from William Rathbone 18.08.1887:2

[27] LMA A/RNY/124 Biblework at Home and Abroad 1888:360

[28] LMA H1/ST/NC18/33/3 Draft report of the sub-committee of reference and enquiry on district nurses in London

[29] This may be the case for other developing occupations as well.

[30] LMA H1/ST/NC18/33 First quarterly report of the superintendent general 1875:2

[31] BL add. ms. 47756

[32] LMA H1/ST/NC18/33/5 First quarterly report of the superintendent general:14

[33] Wellcome SA/QNI/F1/4 14.08.1887

[34] Queen's Institutes were established in England and Wales, Scotland, and Ireland, but this thesis will only consider developments in England.

[35] Wellcome SA/QNI/F1/4 23.08.1886

[36] Wellcome SA/QNI/A1 Memo from William Rathbone 18.08.1887

[37] Wellcome AS/QNI/A2 16.10.1887

[38] See for example correspondence from Dacre Craven (Honorary Secretary of the Central Home) and from Rathbone to Sir Rutherford Alcock (trustee of the Queen's Institute) Wellcome SA/QNI/F1/7

[39] Master of St. Katherine's Hospital and President of the Council of the Queen's Institute

[40] Wellcome SA/QNI/N6.3 'Queen Victoria's Jubilee Institute: its object and its work' 1892. Lecture delivered by Peile A.

[41] ibid

[42] LMA H1/ST/NC18/33/7/1 Annual report 1892

[43] Wellcome SA/QNI/F1/7 02.12.1895

[44] Wellcome SA/QNI/C2/2 Affiliation sub committee minutes 10.06.1890

[45] Wellcome SA/QNI/C1/1 council minutes 02.12.1890

[46] BL add. ms. 47756 14.06.1889

[47] Wellcome SA/QNI/C1/1 council minutes:07.07.1891

[48] By this time he was married to Florence Lees

[49] LMA H1/ST/NC18/25/34 06.06.1894

[50] It is interesting to note that the first plan for Queen's nurses included the idea of three classes of nurse, each with a different length of training

[51] Wellcome SA/QNI/N.6/3 'Queen Victoria's Jubilee Institute: its object and its work':10

[52] Wellcome SA/QNI/P4 Inspector's report 1893

[53] ibid 1892

[54] LMA H1/ST/NC18/28/39

[55] Bodleian Acland papers d70: 20 July 1869

Conclusion

I have been concerned in this thesis to trace the history of district nursing from its emergence in the mid-nineteenth century, to its early attempts at professionalision, around fifty years later. It has not, therefore, been my intention to write a complete history, but rather to explore in some detail the complex web of social relationships experienced by an occupation which has yet to find a place for itself in the occupational *milieu*. To this end, occupation has been viewed both as a set of tasks which provide the focus for claims of jurisdiction, and as a social activity, concentrating on the process of organisation, and on social relationships.

The history of district nursing has generally been 'taken for granted' and subsumed within a more generic nursing history, despite the fact that most nursing work, whether paid or unpaid took place in the home. What holds true for hospital nursing has been assumed to be reflected in district nursing and private duty nursing. For domiciliary nursing this leads to two major omissions. Despite the complexity of the process, the move from an unpaid to a paid occupation is accepted uncritically, and the influence of domiciliary nursing on the development of hospital nursing is overlooked. Diverse organisations such as the Sisterhoods and the Metropolitan Association are treated as homogeneous.

In this final chapter I wish to address three main questions, although attempting to answer them will give rise to others. First, how can the theories of work,

occupations and professionalisation utilised in this thesis, help to explain the emergence and subsequent development of district nursing? Secondly, how can the history of district nursing inform the sociology of professions? Thirdly, I identified in chapter 3 certain social factors, or external forces (Abbott 1988) which it was suggested created the market conditions which facilitated the development of district nursing as a paid occupation. How far has the thesis demonstrated the validity of this claim?

How helpful have theories of 'work', 'occupation' and 'professionalisation' been in explaining the emergence of district nursing? A traditional or common sense definition which treats 'work' and 'occupation' as synonymous is too broad an instrument with which to dissect the multifarious roles involved in district nursing associations. By teasing out notions of what constitutes work, and when that work becomes an occupation I have been able to explain how and why district nursing became a paid occupation. Early Sisterhoods, it is argued, fulfilled a need felt within middle class families for a competent, trained nurse, while simultaneously meeting the need of the Sisters themselves for an alternative to the life of dependence and domesticity expected of their class. They had discovered a niche market, an area of work which they seized by creating a nursing service based on piety and vocation. This could be demarcated from what were perceived as disreputable nurses. They also provided the organisational catalyst for many of the district nursing associations which were to follow. That their labour was unpaid did not consign it to the category of amateur, as the use of Freidson's (1978) distinction between the official and subjective economies makes clear.

Viewing work as a social activity as well as a collection of tasks has allowed an exploration of the diverse ways in which district nursing associations negotiated the tension between the separating spheres of public and private labour, carrying out paid work in domestic settings. It has also facilitated discussion on the relationship that existed between paid and unpaid agents. This led to the notions of use value and exchange value being adopted to unpack the roles of the different actors, in terms of defining their contribution as 'work'.

Here it is necessary to acknowledge the changing status of earning a living, as opposed to possessing inherited wealth. In the twentieth century a higher status is awarded to work which is paid rather than unpaid, especially for those domestic tasks which can be carried out within or outside a pecuniary relationship. In the nineteenth century greater status came from not having to earn a living from one's labours, the gentlemen and players described by Horobin (1983). So Sisters who contributed part of their wealth to the Sisterhood and lady superintendents in the secular associations had supervisory and moral authority over the waged nurses. It was often said that only women of a high social status would possess moral qualities and the willingness to perform nursing work from non-pecuniary motives. What was ignored was that these were the only women who were able to undertake *any* form of work without regard to wages. The hierarchies which pertained to district nursing associations reflected the values of the time concerning different forms of income.

This was, however, turned on its head by the argument of Miss Frere in 1848, in demanding a paid superintendent for St. John's House, and later by the insistence by the Metropolitan Association and the Queen's Institute that only

trained superintendents could supervise their nurses. Miss Frere did not conform to the dominant thinking on the value of paid and unpaid officials, but by the time the Metropolitan Association and the Queen's Institute were using this argument, both the relative values of paid and volunteer labour, and the acceptability of paid work for women were changing.

Viewing work as a social activity led to the consideration of the concepts of social closure and jurisdiction to explain certain aspects of district nursing development as a paid occupation. Training was utilised in the first instance to demarcate the work of nurses, and to ensure nursing's subordination to medicine. Once this had been achieved it was used as a credentialist tactic both in order to attract educated women into district nursing, and to assist professionalisation by developing from a domestic to a scientific model, based upon medicine. Demarcatory tactics by the Metropolitan Association and the Queen's Institute included 'nursing the room', not giving relief, and moving from lady to trained superintendents. These dual closure strategies would, it was hoped, define district nursing and distance it from other forms of domiciliary nursing, and from philanthropic effort. The problem was that professionalisers among district nursing could not force these strategies onto other associations, nor could they claim jurisdiction over a discrete area of work. The fact that nurses transferred between district and private duty work, with its link with domestic service, and the lack of any distinctive tasks that could justify the term profession, further hampered attempts to create in district nursing a profession for educated women.

It must, however, be asked whether 'profession' in the way it is being used here, as an analytical tool, is a twentieth century categorisation, not appropriate

for the examination of nineteenth century occupations? An issue that has been assumed rather than explored is what the Metropolitan Association and the Queen's Institute actually meant when they referred to nursing as a profession. Freidson (1996:3) defines professionalism as the occupational control of work, that is the occupation itself chooses who is to carry out work, and on what terms, and decides what tasks are to be performed and how. In 1889 Lees (writing as Mrs Dacre Craven) wrote a guide for district nurses, in which she reiterates her belief that a higher education and a higher grade of woman is required for district nursing than for hospital superintendence. However, she goes on to say that the nurse must know how to observe and report correctly, when and how to apply appropriate provisional treatment until the medical man arrives, and to obey written orders. There are elements here of autonomy, for which a higher education might be considered necessary, but also elements of control by, and subservience to, the medical profession.

She also wrote that "the office of nurse is too high and holy for any woman called to it to wish to devote much time to the adornment of her person" and "no nurse should take up district work unless she feels that to serve the poor is her vocation".[1] This is reminiscent of the Sisterhoods with their ideas of piety, a cloistered existence, and obedient service, ideas that were proving remarkably enduring. Florence Lees, and others on the committees of the Metropolitan Association and the Queen's Institute would seem to have wanted district nursing to professionalise within the existing social order, thereby institutionalising existing patriarchal power relationships. This is consistent with Gamarnikov's (1984) assertion that the sexual division of labour was seen as natural in all elements of social life, not just within the family, and that even

in the workplace a patriarchal hierarchy was uncritically accepted. The gender division of labour emphasised task distribution, and as nurturing and caring were seen as part of women's natural role, they formed an uncontested jurisdiction in the official economy. There does not appear to have been any perceived incongruity between obedience and autonomy, vocation and professionalisation. Perhaps as dualistic notions these are twentieth century categorisations, which played no part in the rationale for developing occupations of the nineteenth century.

The use of concepts such as work and occupation has allowed for an analysis which explains the genesis and development of an occupation, before moving on to issues of how and why an occupation may attempt to become a profession. It has therefore permitted a more complete analysis, one which does not assume a primacy for professionalisation over work and occupation. All three concepts are all treated as important facets of occupational development. It is my contention that they are also more inclusive for analysing emerging occupations, since not all occupations attempt to professionalise. Larson's (1977) comment concerning professions having to create as well as protect markets is relevant to all occupations, not exclusively to professions. As Hughes (1971) has stated, much writing about professions is really concerned with occupational development.

How can the history of district nursing inform the sociology of professions? Any conclusions need to be treated with caution because of the nature of historical documents. What has been preserved is biased towards the perspective of those whose normal medium of communication was written; oral

histories have not for the most part survived. Usually this means that the perspective of well known figures, not people at the 'coal face', is what is available to the researcher.

It also needs to be questioned, as Saks (1995) does, whether case studies describe special cases. In this case how far can conclusions drawn about the development of district nursing be said to hold for other occupations?

The history of district nursing would suggest that professionalisation needs to be seen as being a historically specific concept. People such as Lees identified what they were attempting, and their use of the term 'profession', with contemporary male professionalisers in medicine. How this occurred can be illuminating in explaining both how and why the occupation is organised the way it is, and its relationships with other occupations. The emergence of district nursing also demonstrates the limitation of theories of professionalisation, in only considering established occupations, and their moves to professional status.

The problematic nature of the relationship between work and occupation is highlighted by a consideration of the various district nursing associations with their diverse views on such aspects of the role as training, supervision, suitable tasks for nurses to carry out, and appropriate living arrangements. I have examined some of the developments by which district nursing evolved from the Sisterhoods, where subjective labour dominated and controlled the work of paid nurses, to an occupation where the official economy dominated and subjective labour was used to support the work, not to control it. The transition was characterised by paid nurses supervised by lay superintendents, who did not carry out nursing work, therefore the move to a paid occupation

for nurses for the most part preceded the move away from lay to professional supervision.[2]

Freidson and Prochaska both comment on the fact that work can move from the subjective to the formal economy, but neither addresses how and why the move occurs (Maxwell 1998). District nursing superintendence illustrates the process, by its move from the subjective to the official economy as paid labour became more acceptable for middle class women, more of whom were looking for a paid occupation as the century progressed. This enabled organisations such as the Metropolitan Association and the Queen's Institute to attempt professionalising strategies, which, if successful, would encourage those middle class women into nursing. It also highlights the tensions between those who wanted to develop a paid occupation and those who did not, a tension that continued into this century and was the root of a rift between the Queen's Institute and the Liverpool School. Lady superintendents and lay committees were often reluctant to relinquish control, and the Queen's Institute insistence on trained superintendence and inspection hampered its growth and therefore its ability to structure district nursing in the way it wished.

Strategies employed by the Metropolitan Association and the Queen's Institute were not female professional projects in the way that Witz (1992) defines them. Women were not using male structures to advance their cause, but mainly male committees, abetted by a female elite, were attempting projects which would fashion the occupation in a certain way, a mixture of subservience and autonomy. This did not, however, conform to Witz's description of the use of proxy male power in order to represent a collective interest as it has been argued that professionalisation was a minority interest amongst nurses

themselves. Halliday (1987) has argued that the elite and the ordinary members of an occupation do not necessarily have the same goals or interests, and that is certainly the case here.

It is worth reiterating Larson's (1977) distinction between autonomous and heteronomous means of professionalisation. Autonomous means are those whereby the occupation itself plays a major role, and includes areas such as training. Heteronomous means are those defined from outside the occupation, such as the legalistic tactic of registration. Although the means utilised were those normally considered autonomous (credentials and demarcation), for district nursing these were attempted by largely heteronomous means.

Claims for professional status by the Metropolitan Association and the Queen's Institute were based on a dual strategy approach of exclusion and upward mobility by credentialist tactics; and demarcation in laying claim to a distinct area of work, which distanced its nurses from other district nurses and from philanthropic pursuit. This was based on the sanitary ideal and hygiene, Nightingale's 'nursing the room', and the giving of only nursing care and not relief. The Queen's Institute added a further strategy of affiliation. These tactics did not confer on Queen's nurses the status that the Institute craved, nor did it prevent other district nursing associations, with shorter training and different working methods, from functioning. Nursing may have constituted an uncontested jurisdiction within the gender division of labour, but that did not produce a unified occupation with a discrete area of work. I have argued that, for this reason, the strategies of the Metropolitan Association and the Queen's Institute constituted a failed professional project.

To what extent do the social changes identified in chapter 3 - client related and occupation related - give a satisfactory answer to the question of how and why district nursing came to be seen as appropriately paid work? Did they create the market conditions which facilitated the development of the occupation?

Why district nursing emerged is bound up with enlightenment thinking and the rise of a capitalist mode of production. Geographical mobility and a more structured working day in the factories made the care of the sick and dependent by the family or community more difficult. Urbanisation had facilitated institutionalisation, and the care of the sick in hospital, but this could not deal with sanitary failings, nor, indeed, with the majority of illness. These factors had also increased segregation of the social classes which made face to face paternalism and social control difficult, at a time when the perceived threat of political unrest was high. District visiting, including district nursing, was a way of conveying a particular moral culture to the poor which was consistent with enlightenment ideas about free will and self help.

Enlightenment ideas led to the growth of philanthropy, which was culturally and historically specific, and provided the means by which district nursing associations could function prior to large scale state intervention in welfare.

There was also a reaction to the excesses of capitalism which resulted in a genuine desire to improve the plight of the poor, and a widely held view that encouraging them to adopt middle class values of hard work, sobriety and thrift would enhance their lives.

The symbiotic relationship between women, home and philanthropy was influential in the way that district nursing developed. The delineation of home

into a physical and social space affected opportunities for women in the public sphere, but these opportunities were constrained by a gender division of labour which focused on task distribution, and institutionalised patriarchal power relationships. This confined women to the caring and nurturing roles that were extensions of the domestic role. For many middle class women the entry to the public sphere was through the subjective labour of philanthropic pursuit, and it was the existence of working class women in paid labour, especially in the factories, which provided the rationale. However, from the middle of the century many women needed a paid occupation, whether from desire or necessity, and it was again in the nurturing and caring roles that many of them secured one.

Both the lives of the middle and upper class women who comprised the lady superintendents, and the working class women who were the nurses and also the clients were mediated by men, often the same men. As Witz (1992) points out the men whose status was enhanced by their wives' idleness were employing women in mills and factories. Many middle class women rejected the domestic role that was expected of them, and some of these directed their energies to nursing the sick poor, whether in a paid or a voluntary role. For most associations, however, it was not these women but mainly male committees which set the agenda, and decided on the type of nurse to employ, how much training to give, and how to supervise her.

Sisterhoods gave middle class women an entry into an occupation, but they also helped to marginalise existing nurses in the community. They provided a transition between nursing as domestic service and nursing as an occupation based on technical training - although the impetus for training in the first

instance, was obedience. This also helped to make the Sisterhoods acceptable for middle class, single women.

The social factors identified as crucial to the emergence of district nursing, both client related and occupation related, coincided from around the middle of the nineteenth century. Social change created the market conditions in which district nursing could emerge, and it also led to the creation of a potential workforce, both in the official and the subjective economies. Much of this workforce was committed to provide a service to the sick poor, the pursuit of self interest can, thus be seen as compatible with advancing the public interest (Saks, 1995). Self interest and altruism can be viewed, then, as a false dichotomy, since occupations may be involved in many projects simultaneously, not all of which appear compatible unless sociologically unpacked.

Using the idea of Sisterhoods in order to inculcate the idea of obedience and a cloistered existence, may have fulfilled the interests of middle class women in escaping from a life of domesticity, but it also had the effect of changing the image of nursing into that of a vocation. A tone was set from which domiciliary nursing could not escape. By using training to develop obedience to doctors district nursing associations reinforced the image of a subservient workforce. Midwifery, however, which did not train for obedience, was also unable to remain outside the control of medicine, so how much could district nursing realistically achieve at that time within the existing gender division of labour? As Abbott (1988:72) has argued "in the legal and public arenas, medicine argued successfully that custodial care and the administration of hospitals were subordinate to the medicine conducted in them." Nursing was unsuccessful in

attempts at subdividing a full jurisdiction, and had to settle for the subordinate jurisdiction of 'care', which was uncontested, as it was seen as naturally female. We need, however, to question how many domiciliary nurses before the advent of Sisterhoods had real autonomy, how many had much skill? Rafferty makes assumptions about this, and tends to glorify pre-reform nurses, without offering much in the way of empirical support. Summers (1990:126) argues that Dickens' Mrs Gamp was a caricature, but only goes as far as saying of domiciliary nurses that "there were literally thousands of kindly, decent women for whom going out to nurse in the homes of their patients provided an honest livelihood." As there were no controls or regulation, it is likely that the range of skill was great, and autonomy would have been affected by the relative status of the nurse and her patients.

There is, however, some circumstantial evidence in support of the idea that at least some domiciliary nurses were skilful in caring for the sick. Acland in 1858 recommended that a competent nurse was necessary for the fever epidemic in Great Horsham (implying that such a being existed), and the lady superintendent's reports of St John's House occasionally stated that a patient wished his/her nurse to go and work for them permanently, in the case of a Mrs Hawthorne even offering to pay the Institution 26 guineas a year so that the nurse could remain a member. The probability was that the amount of skill was very variable in the absence of any agreed standard, or consensus about what domiciliary nursing actually was.

I have argued that no consensus about training or supervision existed among district nursing associations. The vested interests of lay committees meant that most structured their association in a way that reflected their ideals and values,

and no one group had enough power to influence the others. At this time the voluntary hospitals were also holding on to their diversity in matters of training and resisting the uniformity that nurse registration would have brought. Nurse registrationists at the turn of the century were attempting to use legalistic strategies to achieve their aims, and it is not clear why the Metropolitan Association and the Queen's Institute did not turn to the state for legitimation, when their attempts to unify the occupation over the whole country were apparently failing. This may be because the type of people on the council of both organisations had more in common with the boards of the voluntary hospitals than with the registrationists. They were upper class and aristocratic, rather than the middle class professionalisers of accountancy, engineering etc. The nurses themselves were not agitating for professionalisation. Interestingly, pro-registrationists viewed private duty nurses as the independent practitioners who would be in the vanguard of a professional nursing service, despite their link to domestic service. These nurses were more like the class of women to be found as hospital nurses, yet pro-registrationists did not seem to consider that a district nursing organisation employing only educated middle and upper class women might suit their purposes better.

District nursing continued to develop in this century, and the Queen's Institute and the Ranyard Mission, whose philosophies had seemed so irreconcilable as late as the turn of the century, became the two recognised training systems for London. Much of the growth in associations affiliated to the Queen's Institute was due to the midwifery services offered by the rural nurses (Fox 1994). However, diversity continued and independent workers coexisted alongside trained nurses, with the latter often having to negotiate territory in order to be

accepted in some communities. By the late 1930s it was generally agreed that a voluntary service could not provide an adequate district nursing service (Fox 1994), and this was consistent with views on other aspects of health provision, notably voluntary hospitals.

The inception of the NHS brought more homogeneity to the occupation, but it was still common for local authorities to contract with district nursing organisations for the provision of services. The Ranyard Mission, for example, provided over twenty per cent of district nursing services for the London County Council until the mid 1960s. Training was still not mandatory, and in 1958 the recommended training was set at four months, rather than the six months favoured by the Queen's Institute. Dingwall *et al* (1988) interpret this as elitism on the part of the Queen's Institute in refusing to compromise on its standards, which eventually lead to its downfall. It became only one of the recognised training bodies for a Ministry of Health administered certificate, rather than the only body, as it had hoped. At this time half of all district nurses had no specific training at all, and the concern of the Ministry of Health was to give training to as many nurses as possible.

It was the 1974 NHS reorganisation, in bringing most health services into a unified NHS, which brought complete homogeneity to the occupation in terms of training and structure, and in 1981 a six month training was made mandatory. It was, therefore, organisational changes, the rise of a single purchaser and a single control system, which eventually facilitated professionalisation of district nursing, rather than the long years of exclusionary and demarcatory strategies attempted by the Queen's Institute.

Despite this the legacy of the nineteenth century is still apparent. Earlier discharge of patients from hospital has meant a change of role for district nurses, with the shedding of basic care tasks and an increase in complex treatments. Yet the Audit Commission (1999) has found that few NHS trusts have considered the strategic purpose of district nurses in a changing NHS, and the image of a bonneted, bicycling nurse persists. Although the number of staff nursing patients in their homes has not altered over the past ten years, the number with district nursing qualifications has declined. Qualified nurses increasingly supervise the work of less qualified staff. Demarcatory strategies include redefining what were nursing tasks as 'social care', yet these have still not produced a discrete area of work that defines district nursing.

The subordinate position of care to cure, with nurses subordinate to doctors a still a feature of medical demarcatory politics. Despite the government's expressed intention that a wide group of health professionals be involved in NHS purchasing decisions, doctors have used their powerful position in the medical hierarchy to secure not only a majority on the boards of the new primary care groups, but also a majority for a quorum. According to Groves (1999:748) "General practitioners will run the boards of primary care groups with help from nurses, other primary care staff, and representatives from local authorities and the public."

Many of the issues that frustrated *fin de siècle* district nursing associations would seem to be unresolved as we approach the end of another century.

Notes

[1] Bodleian 15192 e 16 Dacre Craven Mrs (1889) 'A guide to district nurses':5-6

[2] I do not wish to imply here a linear development, rather to summarise some of the important features.

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/A1 Provisional minute books
/A2 Council minute books
/A5 House committee minute books
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